Exhibit D

IN THE SUPERIOR COURT
OF NEW JERSEY LAW DIVISION
BERGEN COUNTY

KATHRYN E. CORBET and ERIC R. CORBET,	)	
Plaintiffs,	)	MASTER DOCKET NO: BER-L-11575-14
VS.	)	
ETHICON, INC., ETHICON WOMEN'S HEALTH AND UROLOGY, a Division of Ethicon, Inc., GYNECARE, JOHNSON & JOHNSON, AND JOHN DOES 1-20,	)	CIVIL ACTION: In re Pelvic Mesh/Gynecare Litigation, Case No. 291 CT
Defendants.	)	

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ORAL AND VIDEOTAPED DEPOSITION OF
WENXIN ZHENG, M.D.
NOVEMBER 18, 2015

****

ORAL DEPOSITION OF WENXIN ZHENG, M.D., produced as a witness at the instance of the Plaintiffs, and duly sworn, was taken in the above-styled and numbered cause on November 18, 2015, from 9:16 a.m. to 5:28 p.m., before Lisa C. Hundt, CSR, RPR, CLR in and for the State of Texas, reported by machine shorthand, at the law offices of Thompson & Knight, located at 1722 Routh Street, Suite 1500, Dallas, Texas, in accordance with the New Jersey Rules of Civil Procedure and the provisions stated on the record or attached hereto.

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PROCEEDINGS

THE VIDEOGRAPHER: We're now on record. My name is John Hines. I'm videographer with Golkow Technologies. Today's date is Wednesday, November 18th, 2015. The time is approximately 9:16 a.m.

This video deposition is being held in Dallas, Texas, in the matter of Kathryn Corbet vs. Ethicon Inc. for the Superior Court of New Jersey law division, Bergen County. The deponent is Dr. Wenxin Zheng.

Will counsel please introduce themselves for the record.

MR. THORNBURGH: Daniel Thornburgh for the plaintiffs.

MR. MORRIS: Brandon Morris for the plaintiffs.

MR. VOUDOURIS: Peter Voudouris for the defendants.

MR. SNOWDEN: Andy Snowden for the defendants.

WENXIN ZHENG, M.D.,
having been first duly sworn, testified as follows:

EXAMINATION

BY MR. THORNBURGH:

Q. Good morning, Doctor.

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A. Good morning.
Q. How are you?
A. Okay.
Q. Good. Can you please state your name -- full name for the record?
A. Wenxin Zheng.
Q. And is it pronounced Dr. Zheng?
A. That's fine.
Q. Okay. I'll do my best. If I butcher your name during the deposition, I apologize.
A. That's okay. No problem.
Q. Doctor, you've been deposed previously?
A. Correct.
Q. Okay. How many times have you given a deposition?
A. I think three times.
Q. Three times in the mesh litigation or three times total?
A. Three times for the mesh litigation.
Q. And was that for the Lewis case -- the -- and the Husky -- sorry, the Lewis case?
A. Lewis case, Husky, and Edwards.
Q. Edwards.
And did you have an opportunity to look at the deposition notice?

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A. Yes.
Q. Okay. I'll mark as Exhibit Number 1 the deposition notice.
(Exhibit Number 1 was marked.)
Q. And when did you review the deposition notice?
A. Last week.
Q. Okay. And did you take some steps to gather records that were responsive to the request for production of documents attached to the deposition notice?
A. Yes.
MR. VOUDOURIS: Dan, if I can help you out. His complete file, including his billing and photographs, I understand, and literature is on this jump drive.
Q. (BY MR. THORNBURGH) We will mark as Exhibit Number 2 to the deposition notice what counsel for Ethicon, Johnson & Johnson, have provided to me, which is purported to be your file in this case.
A. Yes.
(Exhibit Number 2 was marked.)
Q. And what steps did you take to gather the records responsive to the deposition notice?
A. It's mainly from my computer, my desktop.
Q. Okay. And what is your understanding of the

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documents contained within Exhibit Number 2?
A. Can you rephrase your question?
Q. Yeah. And -- and I apologize. If at any time during the deposition, you don't understand my question, just let me know, ask me to rephrase it --
A. Sure.
Q. -- or re-ask it, and I'll do my best --
A. Okay.
Q. -- to ask you a better question.
A. No problem.
Q. But my question to you was: What document -- what is your understanding of the documents that are contained on Exhibit 2?
A. My understanding is just whatever I have read, whatever I produced for my report, maybe part of the document you -- related to this case.
Q. And I think counsel representing you here today indicated that your billing records are contained within Exhibit Number 2. Is that correct?
A. Correct.
Q. Okay. And then your case file, what would your case file include?
A. What do you mean "case file"?
Q. The -- what -- what types of records did you maintain in your case -- in your file for this case?

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A. Okay. Whatever the medical record for -- for the patient Corbet, I received, I will maintain, I will keep in my desk -- in my desktop. And also, whatever the draft I made for my report, I will maintain. And also, the slides I reviewed, the pictures I took and that, generally, also will be maintained in my file.
Q. Okay.
A. And, also, literatures I reviewed relevant to this case also be main -- be maintained.
Q. Okay. And so for the literature that you reviewed relevant to this case, would that include -- does Exhibit Number 2 have the documents -- all of the literature that you reviewed that are -- that's identified in your reliance list on your report?
A. It's not necessarily in -- everything inclusive, but I think more relevant articles I saved.
Q. And you had indicated there were some photo micrographs?
A. Yeah.
Q. Okay. And are there photo micrographs contained within Exhibit Number 2 that are in addition to the photo micrographs that are contained within your expert report?
A. In a few of them, I think it's because when I generate my expert report, I have to use some of these

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pictures rather than the whole pictures. But it's still, all the pictures I took is maintained and it's in the file.
Q. Okay. Do you -- do you recall approximately how many micro -- or photo micrographs are contained within Exhibit Number 2?
A. Probably there's about 20, 25 pictures total.
Q. And defense counsel had indicated also and I think you confirmed that your invoice for the work that you've performed in the Corbet case -- or invoices, perhaps -- are also contained within Exhibit Number 2?
A. Yes. I only billed once for that.
Q. Okay. So one invoice?
A. Yes.
Q. Okay. And do you recall -- because I don't have a --
A. How many hours?
Q. Yeah. Do you recall how many hours you billed on the invoice?
A. I think it's about 49 hours. That was from last year.
Q. And is that at $600 an hour?
A. Correct.
Q. And so all of the work that you've performed last year, the 49 hours, would that represent the time

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that you spent preparing for -- preparing your expert report?
A. Correct. Reading medical records, literatures and prepare reports and reading slides, taking pictures, to prepare for presentations.
Q. Okay. How much time was spent reading the medical literature?
A. Maybe, I think, probably 50 percent of the time. I can't be exact.
Q. And what was the other 50 percent of your time devoted to?
A. And then medical records, understanding the whole situation. And then writing reports and pathology analysis and photograph taking.
(Exhibit Number 3 was marked.)
Q. I've marked as Exhibit Number 3 your expert report dated August 7th, 2014.
A. Yes.
Q. Does this appear to be your full report in the Corbet versus Ethicon case?
A. Yes. From the first page, it looks identical.
MR. THORNBURGH: Counsel. If you don't need it...
MR. VOUDOURIS: I have my own copy. It's 3?

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MR. THORNBURGH: Pardon me?
MR. VOUDOURIS: Exhibit 3?
MR. THORNBURGH: Exhibit 3, yeah.
Q. (BY MR. THORNBURGH) You have -- it appears that you have some additional documents in front of you. What do you have in front of you that you brought with you today?
A. It's my expert report, the same thing as yours. And then Dr. Iakovlev's report.
Q. Okay. We'll go ahead and mark as Exhibit Number 4 the expert -- your export report that you brought with you today.
A. Okay.
(Exhibit Number 4 was marked.)
A. Mine's a single page. Yours is double page, so...
Q. Okay. And are there any -- did you make any changes or anything on Exhibit Number 4 different than Exhibit Number 3?
A. I didn't change at all.
Q. And we'll mark as Exhibit Number 5 the report you brought with you today regarding Dr. Iakovlev.
A. Yeah.
(Exhibit Number 5 was marked.)
Q. Did you bring any other documents with you

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today other than the documents contained on Exhibit Number 2, the -- which is the thumb drive, or Exhibit Number 3 and 4?
A. No.
Q. Now, I know that you billed, you said, 49 hours last year in preparation for your expert report. How much time have you -- strike that.
Regarding the 49 hours, do you know what the invoice date is?
A. Last year sometime. I don't remember exactly. Maybe --
Q. It will be identified on Exhibit Number 2, right?
A. Right.
Q. Have you done additional work in preparation for this case or this deposition that's not contained within your invoices on Exhibit Number 2?
A. Oh, yes. Because after a year, then, you know, not really I can remember everything.
Q. Okay.
A. So therefore, when I received a notice from Mr. Snowden saying this case is going to be on deposition, and then I start to review again.
Q. Okay. And how much time have you spent reviewing and -- the case and preparing for this

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deposition?
A. Because I have additional medical records coming that I have read. And then I do a new literature search and additional findings. And then, also, have to review my -- what I have written, because I may not remember what I have done in the past. That's a year ago.
Q. Okay. So let me make sure I under -- I'm sorry. Were you done?
A. Yeah.
Q. Let me make sure I understand. So since last year, you have -- and after the -- the date of your -- your invoice, you have reviewed additional medical records. How much time have you spent reviewing additional medical records?
A. Oh, I don't remember exactly, because this is through e-mails, you know, from Butler's law office sending -- e-mail these medical records, and I have to download and read, probably, several hours. I have no idea exactly how -- how many hours I have spent for that.
Q. Okay. You also indicated that you did a new literature search and additional findings. What do you -- how much -- well, strike that.
You also indicated that did you a new

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literature search. How much time did you devote to doing additional literature searches?
A. Several hours. I think mainly I want to see if there's any recent advances in the field to see, you know, whether there's any new publications related to this topic.
Q. Did you identify any additional new literature that you felt was relevant to your opinions?
A. Yeah. I have the two most relevant publications, I think. One is Hill's article. The other is Dr. Smith's article regarding histological finding from those explanted mesh specimens.
Q. Okay. So Hill's article?
A. Right.
Q. And I think you said Smith?
A. Smith.
Q. Is that the same article?
A. Different.
Q. Different articles?
Did you include those two articles on -- within Exhibit Number 2?
A. I believe it's there in the -- Exhibit Number 2, yeah.
Q. Okay. And what significance did the Hill and Smith articles have in this case?

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A. I --
MR. VOUDOURIS: Objection; compound.
Go ahead.
THE WITNESS: Okay.
A. Okay. I think based on my impression, Hill's article basically study the explant vaginal mesh dividing into three groups. One group was, like, a voiding dysfunction, then the other group is -- was pain then /erosion and then the third group, combination of these two. Then compared the amount of information they found from histological findings.
Q. (BY MR. THORNBURGH) And do you recall what their conclusions were regarding voiding dysfunction?
A. Right. The conclusion is a little bit surprise to me, also -- probably also, it's reasonable. Because they found in the voiding dysfunction group, these patients has highest amount of inflammation compared to those patient complain with pain or even erosion.
Q. And why was that significant or surprising to you?
A. Because, typically, if it's -- there is erosion or exposure -- what's called mesh exposure to outside surface -- then you should have more inflammation.

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Q. Okay. So was there an association made by these authors or some of these authors that mesh exposure was associated, number one, with an increased inflammatory response, and, number two, with an increased risk of voiding dysfunction?
MR. VOUDOURIS: Objection.
Go ahead.
A. I don't think they -- they concluding that way.
Q. (BY MR. THORNBURGH) What was their conclusion? Did they correlate the two?
MR. VOUDOURIS: Objection.
A. I think they correlate mainly to see if the inflammation may contribute one of these critical findings, but their finding is they're more associated with the voiding dysfunction group.
Q. (BY MR. THORNBURGH) So increased inflammation in women who have had mesh implants had an increased risk of voiding dysfunction as a result of the inflammation?
MR. VOUDOURIS: Objection.
A. No. I -- I don't think that you can conclude in that way. That's not in my understanding.
Q. (BY MR. THORNBURGH) I think your answer was they correlate mainly to see if the inflammation may

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contribute to one of these critical findings, but their finding is they're more associated with the voiding group. What do you mean by that?
A. It's -- that's -- that's the descriptive finding, all right? It's basically association. Does not necessarily meaning one is the cause, the other is the results.
Q. But in any event, they found that for women implanted with mesh devices who had an -- had an increase in inflammatory response, there was an association -- or an increased association of voiding dysfunction?
MR. VOUDOURIS: Object to form.
Q. (BY MR. THORNBURGH) Is that -- is that fair and accurate?
A. I think my understanding is more inflammation is associated with patients with voiding dysfunction. That's it.
Q. And those patients had mesh implantation?
A. Yes.
Q. And you also indicated that there was -- that they looked at -- strike that.
You also indicated that one of the things that they studied -- I'm sorry. Strike that.
The voiding dysfunction, is that the Hill

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article or the Smith article?
A. That's in the Hill's article.
Q. Okay. And the pain and erosion, is that the Hill article or the Smith article?
A. Also Hill's article.
Q. Okay. And --
A. Those three groups I just mentioned that.
Q. And what did the authors in the Hill article conclude regarding women implanted with mesh devices and the complications of pain and erosion?
MR. VOUDOURIS: Objection.
Go ahead.
A. I don't think they -- they try to concluding that way. They just try to see whether these groups of these patients to have more inflammation maybe associated with one or the other. That's the basic study.
Q. (BY MR. THORNBURGH) And did they find that women implanted with mesh devices who had an increase in inflammation also had pain and erosion?
MR. VOUDOURIS: Objection.
A. No. They have actually less.
Q. (BY MR. THORNBURGH) So it's your -- it's your -- your testimony that the authors who published the Hill article concluded that women who have pain and

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erosion have less inflammation?
A. Correct. That's their conclusion.
Q. And then final -- you said the last subissue in the article was a combination of voiding dysfunction, pain, and erosion. What do you mean by that?
MR. VOUDOURIS: Objection.
Go ahead.
A. They combine these two groups and compare to see what happens.
Q. (BY MR. THORNBURGH) And what were their conclusions when they combine the two groups?
A. They basically -- if they combine these two groups, shows no difference between mesh exposure versus pain and also in combination with voiding dysfunction.
Q. And what was significant to you in your mind in -- for the Corbet case regarding the Hill article?
A. And I think overall, basically, inflammation does not play a bigger role for mesh implants. I think that's the overall message when I read this article.
Q. What about voiding dysfunction?
A. Voiding dysfunction, they found a little more inflammation, mainly -- probably related to urinary tract infection issues. Because when any patient has a voiding dysfunction, then has increase the chance to get bacteria infection, therefore, more inflammation can be

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found.
Q. And what was significant in your mind regarding their findings of pain and erosion?
A. Pain --
MR. VOUDOURIS: Objection.
Go ahead.
A. Pain and erosion overall is a lower incidence among all these -- the patients received mesh implants, TVT or TVTO; overall is lower incidence.
Q. (BY MR. THORNBURGH) What was the incidence rate described in the Hill article concerning women implanted with mesh devices and pain and erosion?
A. And I think they -- based on the subjects they studied -- I don't remember exactly how many -- you know, each group has how many patients there -- but these patients does not also represent overall population of the patient who received TVT or TVTO implants.
Q. That's -- that's your opinion, right?
A. That's my understanding.
Q. That wasn't the opinion of the authors of the Hill article, correct?
A. That's -- that's my understanding after reading this, yes.
Q. Is that your opinion, or was that the opinion

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of the authors in the Hill article?
A. That's what I said. After reading this article, my impression isn't that way. Okay. But if you want to study this one, it's better probably to read -- take this article again.
Q. Yeah, we'll -- we'll -- maybe what we'll do on a break is we'll -- we'll print out those articles.
A. Right.
Q. Okay. We'll talk about --
A. And then we can study paragraph by paragraph.
Q. Do you recall how many explants were analyzed by the researchers in the Hill article?
A. It's about over a hundred, yeah.
Q. And do you recall which -- which devices were analyzed?
A. What do you mean "which devices"?
Q. What -- was it sling -- mesh sling devices, mesh devices used for repair of pelvic organ prolapse, or a combination of the two?
A. I didn't pay that attention. Probably majority of them, they're sling -- a sling device.
Q. And regarding the Smith article, what -- what was that article about?
A. I think Smith article is interesting because they noticed the -- pathology department, when they

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receive all these explanted mesh specimens, they have very heterogeneous way to handle the specimen. So therefore, they try to study to see if there any better way to handle these specimen, more uniformly. Because more and more these days, any hospitals they start to receive more explanted specimens.
And then they found, actually in the past, 50 -- almost 50 percent of them, they just do not have any microscopic examination. I think that's -- that's the -- the -- the same experience I have encountered in the past.
Q. So let me back up a little bit on this -- on the Smith article. Again, we'll print that out if we --
MR. THORNBURGH: Is there a printer here that we can have someone print an article during a break, these articles?
MR. VOUDOURIS: Sure. I imagine it wouldn't be a problem.
Q. (BY MR. THORNBURGH) Okay. But to go back real quick on the Smith article, you said that hospitals are receiving more and more mesh explanted specimens?
MR. VOUDOURIS: Objection.
A. Correct. Based on my understanding, yes, compared to the years -- like five years ago, yeah. These days, more specimens coming to the hospital in

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different places.
Q. (BY MR. THORNBURGH) Okay. And you also indicated that their finding was that 50 percent had no microscopic examination?
A. Right. Based on the Smith article, they mentioned that.
Q. Does that mean that there were 50 percent of mesh specimens that were not analyzed microscopically?
A. They analyzed grossly and recorded grossly and do not submit routinely for microscopic examination. That's the classical way for pathology department to handle these so-called foreign body material.
Q. And so was it the -- did the Smith authors -- the authors of the Smith article, did they suggest that new protocols needed to be in place so that more of these mesh specimens that are sent to pathology departments are actually looked at and analyzed microscopically?
A. I think so, yes, they did.
MR. MORRIS: Is it -- is it Smith or Schmidt?
THE WITNESS: Smith, S-M-I-T-H.
MR. MORRIS: Okay, thanks.
Q. (BY MR. THORNBURGH) And for -- for Hill, is it H-I-L-L?

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A. Correct.
Q. And are you in agreement with the authors of the Smith article that for mesh specimens that are explanted from women, more microscopic analysis needs to be conducted?
A. I think so. Particularly in these days because many legal issues involved, I think it's reasonable to have a standard way to handle these specimens should include microscopic examination.
Q. Did they recommend a pathology registry program where specimens would be provided to a central location or locations, analyzed microscopically and then the pathological findings reported in the registry?
A. I don't remember they have this kind of sentence, no.
Q. Did they discuss the number of mesh specimen explants at any particular hospital?
A. I think also from the single institution, from their institution. I don't remember which one is that. But it's recorded in the -- in the publication.
Q. Okay. So they -- they were reporting on their single institution?
A. I think -- my memory -- I didn't pay detail attention to where these specimens came from. I think I just answered the overall situation. That was my

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impression.
Q. Did they indicate in their publication how many mesh explant specimens have been received by their institution?
A. I think it's -- it's better to review the material method in the article.
Sir, let me ask you, you are reading whatever -- it's already recorded?
MR. THORNBURGH: Yeah, off the --
MR. VOUDOURIS: Off the record.
THE WITNESS: It's a simultaneous --
THE REPORTER: Wait, wait. Off the record or --
MR. VOUDOURIS: Off the record.
THE REPORTER: Let the videographer...
THE VIDEOGRAPHER: Off the record at 9:46 a.m.
(Off the record.)
THE VIDEOGRAPHER: We're back on record at 9:47 a.m.
Q. (BY MR. THORNBURGH) Okay. So let's go back to the question I'd asked before we started talking about the Hill and the Smith articles.
A. Okay.
Q. And I'd asked you how much time you'd spent in

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the case -- this case preparing for this deposition. And you had indicated that you had additional medical records, and then you did a new literature search, and you identified Hill and Smith. Are there any other new literatures -- or new -- strike that.
Were there any other new articles that you found to be relevant and significant to your opinions?
A. I think many of the articles I have read, but I don't think will influence my opinions regarding the pathology part, so therefore, I did not pay a lot of attention to this.
Q. So you didn't -- you didn't rely on any additional articles since your report that you thought were significant or relevant in -- in your opinion?
A. Correct.
Q. Other than the Smith and the Hill articles?
A. Because these are two pathology-related articles, pathological findings. It's similar work what I'm doing.
Q. Okay. You -- after you had indicated that you did a new literature search, you also said that -- and additional findings. What did you mean by "additional findings"?
A. Additional articles, basically. You have -- you do have several other articles published after my

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report, basically within a year period.
Q. Okay. So you were -- when you said additional findings, you weren't talking about additional findings with respect to your review of the --
A. Of the literature. I mean, additional --
MR. VOUDOURIS: Hold on. Doctor --
Q. (BY MR. THORNBURGH) Yeah. Let me try to finish the question.
Because -- you weren't -- you were only talking about the literature, you weren't talking about additional findings with respect to either your review of updated medical records or your review or re-review of the pathological specimens that you have related to Ms. Corbet?
A. Let me, yeah, rephrase my answer. So basically, additional findings that's additional literature findings.
Q. Okay.
A. It's not additional pathological findings from Corbet case.
Q. So the additional -- additional time that you spent preparing for this deposition was also your review of -- your re-review of the medical records and your report?
A. Yes. I have to refresh my mind, because

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that's -- that was written a year ago and I don't expect myself I can remember everything I have done.
Q. Okay. Did you review any additional -- strike that.
Were you provided with any additional internal Ethicon documents?
A. Yes.
Q. And did you -- the reason why I'm asking this question is because I never received a supplemental -- you haven't supplemented your expert report, right?
A. I don't have any supplement expert report.
Q. And you haven't supplemented your reliance list, correct? Your -- the list of materials that you're relying on?
A. No.
Q. All right. You haven't --
A. No, I haven't.
Q. -- supplemented your reliance list or your expert report?
A. No.
Q. The additional internal Ethicon documents that you claim to have reviewed since your report was -- strike that. Let me just make sure I understand.
Are you saying that you've reviewed additional internal documents since you -- since you

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drafted and served and signed your expert report?
A. Yes.
Q. Okay. Are those additional internal Ethicon documents contained within Exhibit Number 2, the thumb drive?
A. I think so.
MR. VOUDOURIS: They are.
Q. (BY MR. THORNBURGH) Do you recall which -- or what internal Ethicon documents you have reviewed which are contained within Exhibit Number 2?
A. I don't remember exactly what's the name of these documents, but I think if you really want to be sure what I -- what was included, you may just print a list, then we can discuss would be better.
Q. Do you recall what relevance those new additional Ethicon internal documents had with respect to this case?
A. I think there is one interesting internal study by Mr. McLean -- or I'm not sure what last name.
Q. Dr. Berkeley?
A. McLean -- I have no -- not exactly. Start with M, anyway. Okay. And -- yeah, if you can show me, that would be better, if you have it.
Q. Well, you know, what we'll do is, on a break, we'll look at your Exhibit Number 2 --

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A. Right.
Q. -- and we'll have any additional Ethicon documents printed.
A. If you would like to print out, that would be better that way.
Q. Okay. Any other -- is it just one additional internal Ethicon document?
A. Yeah. I think this one, because he did some experiments that -- that's interesting experiments.
Q. And what interesting experiments were conducted?
A. So basically, the experiments was to try to demonstrate if the TVT filaments after oxidization then can generate these, like, bark-like material or can retain the stainings as -- as suggested by Dr. Iakovlev. And then the conclusion is -- the answer is no.
Q. Okay. So let me just make sure I understand. So --
A. Right.
Q. So you -- what you thought was an internal -- or what you -- what you represented as being an internal Ethicon document is actually not an internal Ethicon document but the expert report of Dr. Steven McLean?
A. Steven McLean, yes, correct.
Q. Okay.

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A. Is this the one you refer to or no? This is --
Q. Well, I had asked -- my question to you was, what internal Ethicon documents have you reviewed?
A. Oh. I -- I believe this looks like internal, because not, like, published already.
Q. You understand that Dr. McLean is not identified or disclosed as an expert in the Corbet case? Do you know that?
A. I -- I'm not aware of this. But anyway, this is the material I received and that I read. Because I don't have habit to correlate who represents who and what is what for those. And these -- these documents -- when I review I feel is interesting, that's it.
Q. Okay. And so you're talking about the -- the opinions of Dr. McLean concerning his experiments of intentionally oxidizing TVT mesh specimens?
A. Yes.
Q. Okay. And do you recall how he attempted to intentionally oxidize those mesh specimens?
MR. VOUDOURIS: Objection.
Go ahead.
A. Not in detail. But I think if we can open the document and read through and I think that will refresh my mind a little bit.

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Q. (BY MR. THORNBURGH) Okay. Do -- do you recall him conducting in part of his experiment a test to -- strike that.
Do you recall that as part of his experiment he did use UV light?
A. UV light as the -- as a demonstrative method for oxidization, that's true.
Q. Okay. And -- and UV light is -- strike that.
You'd agree with me that women that have mesh implanted in their bodies, their mesh isn't exposed to UV light, correct?
A. That's different. That's true. However, the point is, because there is in no way to do a human -- use a human body or use a woman to do experiments like this at this moment, because ethically it's not allowed --
Q. My -- my --
A. -- and also not practical.
Q. I'm sorry. But my question was, you understand that UV light does not mimic the degradation process that occurs in the human body when the mesh -- the mesh specimens are exposed to enzymes, neutrophils, macrophages, and -- and things of that nature, correct?
MR. VOUDOURIS: Objection; form.
A. From that point of view, yes. However,

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because the -- degradation -- the overall degradation process claimed by Dr. Iakovlev is because of these inflammatory cell that produce oxidative -- oxidative stress. Therefore, these oxidative stress can be mimicked by some other way to try to simulate similar condition. That's the experiment.

Q. (BY MR. THORNBURGH) Right. But the ex vivo experiment conducted by Dr. McLean, you would agree, would -- used UV light to radiate the mesh specimens which doesn't occur in the human body?

A. That's different thing, yes.

Q. So you agree with me?

A. I think from that point of view, yes, you have a correct statement.

Q. And the second experiment that he performed was using chemicals where he exposed mesh -- a mesh -- or mesh specimens to certain oxidizing chemicals for a period of about four and a half weeks?

MR. VOUDOURIS: Objection.

A. I don't remember exactly how long, what exactly he did. I think if you really want to review what is the process, I think it's better to read the article rather than just based on my memory. Because these days, in addition to prepare the -- the deposition, I also have to work. I have many other

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things. I'm not the full-time just work on this, okay, so...

Q. (BY MR. THORNBURGH) Did you consider any of the publications concerning in vivo degradation which found that in order to identify through scanning electron microscopy or other techniques -- strike that.

Did you look at any -- or consider any of the publications, medical or scientific publications, which indicate that in order to get breaking on the outer shell or cracking on the -- the surface layer of implanted meshes, that they have to be implanted for a period of about a year or more?

MR. VOUDOURIS: Objection; form, foundation.

A. I still don't understand what your question.

Q. (BY MR. THORNBURGH) Yes. So let me -- I -- I think I asked a very poor question, so let me try again.

Did you consider any scientific or medical publications that concluded that in order for mesh to crack on the surface, to identify cracks on the surface, that mesh needs to be implanted for a period of longer than one year?

MR. VOUDOURIS: Same objection.

A. I'm a pathologist, okay? I read slides and the microscope. Was my experience, I did not see any

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evidence of degradation. That's -- that's why I barely pay attention to these electron microscopic kind of very -- you magnify those things to a very high level to see these cracks. You know, those -- for me, it's really not relevant. That's the -- basically, that's my understanding. Therefore, I don't -- do not pay attention to those.

Q. (BY MR. THORNBURGH) So you don't consider the medical or scientific publications that have been published in peer-reviewed articles that looked at explanted meshes after a period of time in -- in the -- in the body and used techniques such as scanning electron microscopy and concluded that the mesh had degraded in vivo?

MR. VOUDOURIS: Objection; form, foundation.

Q. (BY MR. THORNBURGH) Let me ask -- let me -- let me ask a better question. You didn't consider any of the scientific or medical peer-reviewed publications where the scientists had concluded that the mesh had degraded in vivo?

MR. VOUDOURIS: Objection; form, foundation.

A. Well, as I said, based on my own experience and I do not see any evidence of degradation, that's

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number one. Because from tissue response to -- adjacent to the mesh, whether there is a so-called bark-like material or no bark-like material, all the tissue response, they look the same, similar, number one.

Number two is, there is no any clinical significance regarding these so-called degrade -- the bark-like material with or without shows any clinical difference from those patients. So therefore, my understanding is there is no meaning -- or no evidence to say to -- to -- to lead me to look for evidence that there is a truly degradation from those implants.

MR. THORNBURGH: Okay. Move to strike nonresponsive to my question.

Q. (BY MR. THORNBURGH) My question was simply: You testified that you didn't find the studies that looked at explanted meshes using scanning electron microscopy and concluded that the mesh had degraded to be relevant to you --

A. Correct.

Q. -- in this case, right?

A. Correct. Therefore, I did not pay attention to these articles.

Q. So you didn't consider them, right? It's a simple question.

MR. VOUDOURIS: Objection.

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A. I did not read these articles.
Q. (BY MR. THORNBURGH) Okay.
A. Okay.
Q. Doctor, what is -- in the path -- in the pathology field, do you understand what I mean by chatter? Do you know what chatter is?
A. I don't know what is chatter. Can you explain?
Q. Yeah. Have you -- when a -- when a microtome is used --
A. Uh-huh.
Q. -- and cuts through, you know, has a cross-section, the mesh tissue and specimen -- strike that.
When a microtome is used to create slides --
A. To make sections.
Q. -- can a microtome sometimes scratch the surface of the -- for example, a polymer -- and cause what is known in the pathology field to be chatter or an artifact?
MR. VOUDOURIS: Objection.
A. Yeah. That's so-called a cutting artifact, a section artifact. That's very common in the pathology lab.

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Q. (BY MR. THORNBURGH) Have you heard of it referred to as chatter before?
A. No.
Q. In any event, it's when the microtome causes scratching on -- on the specimen that you're analyzing under the microscope?
A. Right.
Q. And that's just an artifact caused from the blade, right?
A. Right. That's related to the blade. That's why there is a rule after a certain usage, the blade should be changed.
Q. And if you are seeing this artifact on specimens that you're analyzing, does that indicate to you that the blade should be changed?
MR. VOUDOURIS: Objection.
A. It is not obvious in the routine microscope examination from this Corbet case, okay? I do not see apparent sectioning artifact to cause like a fragmentation or scratch linings, those things, I don't see that.
Q. (BY MR. THORNBURGH) No, I'm not -- I'm not asking you in this case. I'm just saying, generally, as a pathologist, if you are getting this artifact of the microtome blade scratching the specimen that you're

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trying to analyze, that is an indication that you need to -- need to change the blade of the microtome, right?
MR. VOUDOURIS: Objection. Hold on a second, Dan. We talked about before and there's agreement that this deposition is case specific to Corbet. He just answered you, and he told you that he didn't find any artifact when he looked at the Corbet slide. So I think you're going past the agreement about fact specific Corbet questions.
MR. THORNBURGH: Well, I'm not -- number one, I'm not trying to do that and that's not my intention. He had indicated that an additional thing that he has reviewed since his expert report was served was the McLean report. And so I'm asking him questions that are relevant to the McLean report.
MR. VOUDOURIS: Well, they're not relevant to Corbet, but...
MR. THORNBURGH: If he's relying on them in this case -- if he's not relying on it, then that's fine.
MR. VOUDOURIS: You didn't ask him if he was relying on that -- that part of McLean for his opinions in this case.
Q. (BY MR. THORNBURGH) Are you relying on the McLean -- Dr. McLean's report?

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A. I'm not fully rely on Dr. McLean's report, but I -- as I mentioned, when I read through his report, looks -- sounds interesting. And because there is particle issue there, staining issue, that's relevant to what Dr. Iakovlev claim, so that's -- that was the reason.
Q. Have you reviewed any other -- or strike that.
So to go back to my original question, have you reviewed any additional Ethicon internal documents, and your response was you looked at the McLean expert report. So let me try to clarify. Have you looked at any additional Ethicon internal documents since you issued your expert report?
A. I don't remember many other -- there is one old report I briefly scanned through. That was back to 1983, something like this kind of report. That was a long time ago. But the pictures, the printout -- the pictures is very poor quality. They not look very good, so, therefore, I did not pay much attention to that. But I did receive this.
Q. So you looked at some internal document dated from 19 -- from the 1980s that you looked at but you disregarded because the pictures were not of good quality?
A. Right.

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MR. VOUDOURIS: Objection.
A. And there -- I feel may not be very relevant for that.
Q. (BY MR. THORNBURGH) Did you ask Ethicon's lawyers to provide you with better copies of the images that they have or may have in their files?
A. I -- I didn't. Because I feel that was a long time ago and they're -- back to 1980s. And right now is 2015, is over 30 years.
Q. So you didn't consider that in this case, the article -- that -- strike that.
So you didn't consider this 1980 internal Ethicon document in this case because, number one, the date, and number two, because of the poor quality of the images?
A. Poor quality, right. And that's why I did not pay a lot of attention. I did not use that as a -- or studied that for -- for my deposition.
Q. And so I think I know what document you're referring to.
A. Right.
Q. Correct me if I -- if I'm wrong, but you're referring to an internal Ethicon document from 1980s where Ethicon received explanted prolene sutures, correct?

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A. Correct.
Q. And they analyzed those sutures using histological methods similar to the methods that were employed by Dr. Iakovlev in this case, correct?
MR. VOUDOURIS: Objection.
A. I really -- frankly speaking, I really don't know the detail of this, because first of all, one is, as I mentioned, the time is a long time ago. Two is the quality of the pictures are very poor. For me, it's difficult to compare what they're saying, you know, what they tried to document.
Q. (BY MR. THORNBURGH) Did you read the section in the document called methods?
A. So then -- then additionally, I think I really don't have time to read all the stuff within this -- this is pretty thick, based on my memory --
Q. That's fair.
A. -- so I -- I didn't go through.
Q. That's fair.
A. Right.
Q. So you were -- you felt rushed and didn't have enough time, so you didn't go through the -- the document --
A. The detail for these things.
Q. Okay.

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A. And I flip through --
MR. VOUDOURIS: Objection.
Go ahead.
A. I flip through these -- a few pictures, looks -- and the picture does not look very good.
Q. (BY MR. THORNBURGH) So you looked at the pictures, you looked at the date, but you didn't read the content; is that fair?
A. Uh-huh.
Q. Because you were rushed?
A. That's fine.
Q. Did you look at and consider any additional internal Ethicon documents other than the 1983 internal memo that we just discussed?
A. I didn't.
MR. THORNBURGH: Take a break?
MR. VOUDOURIS: [Nods head.]
THE VIDEOGRAPHER: We're off record at 10:12 a.m.
(Break taken.)
THE VIDEOGRAPHER: We're back on record at 10:20 a.m.
Q. (BY MR. THORNBURGH) Doctor, before we went off the record, we were talking about the one additional Ethicon document that you reviewed since your report.

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And that document was provided to you by Ethicon's counsel?
A. Correct.
Q. And, in fact, all of the internal documents that you have reviewed have all been provided to you by Ethicon, correct?
A. Correct.
Q. And that document wasn't provided to you until after you had testified in three other Ethicon cases, correct?
A. I don't remember exactly, but previously, I also have received possibly similar documents, but I'm not sure.
Q. Okay. But the document that we discussed earlier from 1983 --
A. Uh-huh.
Q. -- which was a histopathology study looking at microcracking on explanted prolene sutures, that document wasn't provided to you until after you'd already testified and reached opinions in the Lewis, Husky, and Edwards cases, correct?
MR. VOUDOURIS: Objection.
A. But based on my memory, it looks like that, yes.
Q. (BY MR. THORNBURGH) And that document was

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provided to you after you had already issued and signed your expert report in this case, correct?
A. That was only recently, therefore, yes.
Q. When was that document provided to you?
A. A couple weeks ago.
Q. It was provided to you a couple of weeks ago and you didn't have time to review the text and content of the document other than the date and the pictures?
MR. VOUDOURIS: Objection.
A. I think I have time, but I just didn't pay attention to these, because my opinion is not -- not going to rely on those documents, therefore, I didn't go through.
Q. (BY MR. THORNBURGH) So you had time, you just didn't review it?
A. Yeah.
Q. And, in fact, regarding all of the -- how many internal Ethicon documents have you looked at in this case?
A. So if you consider this is one, then the other one is McLean's paper, and I think these are the two I have received.
Q. The internal documents that Ethicon provides to you are chosen by Ethicon, correct?
MR. VOUDOURIS: Objection.

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A. I did not ask, therefore, you know, I -- yes, Dr. Snowden's office sent me these documents.
Q. (BY MR. THORNBURGH) You meant Mr. Snowden, right?
A. Yeah. I mean, Mr. Snowden, yeah.
MR. SNOWDEN: I got a promotion.
Q. (BY MR. THORNBURGH) Okay. And --
MR. VOUDOURIS: Well, a juris doctor is a doctor, right?
Q. (BY MR. THORNBURGH) You had no -- no input in the types of documents that were provided to you, correct?
A. No.
Q. And so you have to rely on Ethicon to provide you with documents that are relevant to this case, correct?
A. No. I rely on the slides I received and my expertise I have. Then I generate my opinion. That's the main thing I rely on.
Q. So are you telling this court and the ladies and gentlemen of the jury if Ethicon has internal documents discussing Ethicon's scientists' study of explanted prolene sutures for degradation -- in vivo degradation, those internal documents would not be important to you in this case?

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MR. VOUDOURIS: Objection; form, foundation.
A. As I mentioned to you a couple of times, one is a very old document. Two is, I don't feel this is very much relevant to today's findings, all right. That was 30 years ago. And then three is, the picture, the quality was very poor, so it's difficult to compare what is really, you know, what they mean at that time.
Q. (BY MR. THORNBURGH) But if Ethicon has additional internal documents concerning studies that were performed by Ethicon's scientists of explanted prolene sutures, those would be relevant to you, wouldn't they?
MR. VOUDOURIS: Objection; form, foundation.
A. Well, that's -- that's why I say based on my understanding at that time, I don't think this -- there's not much relevance, because my focus is on what I have expertise, number one. Number two is, what the slides I received and what the clinical information I have. Then I render my opinion, okay?
Then, plus, as I also mentioned to you, degradation versus nondegradation. Based on my observation, there is no evidence -- no histological evidence for me to say there's any evidence of

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degradation. Therefore, I do not consider those documents I will rely on that are relevant to -- for my opinion.
Q. (BY MR. THORNBURGH) So if -- you're telling the ladies and gentlemen of this jury and this judge that if Ethicon has internal documents where their scientists concluded that the prolene degraded in vivo, you wouldn't find that important or relevant to your case -- to your opinions?
MR. VOUDOURIS: Objection; asked and answered.
A. I think you're repeating -- repeat -- asking the same question, and my answer is still the same. And there -- these -- my opinion is mainly rely on the material I have received, like the slides, okay? Because I'm a pathologist, okay? Number one.
Number two is, also, I rely on the clinical findings for the -- for this case, right? Then I render my opinion. I do not -- I can't have all these, like, reading all the materials, you know, within the field or even internal for that particular case, the internal document from Ethicon. As I mentioned, one is, too old. Two is, quality of the picture is not good. So therefore, I don't know how can I evaluate for that.
Q. (BY MR. THORNBURGH) But in all fairness,

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Doctor, you're a paid expert witness in this case, right?
MR. VOUDOURIS: Objection.
A. That's right.
Q. (BY MR. THORNBURGH) You're being paid $600 per hour to evaluate Mrs. Corbet's case, right?
A. Yes.
Q. And you are being paid $600 per hour to testify today, right?
A. Yes.
Q. And you're going to be paid $600 to testify at trial, right?
MR. VOUDOURIS: Objection.
A. Yes; if I go.
Q. (BY MR. THORNBURGH) But you didn't find it important enough in this case to review documents created and generated by Ethicon scientists before this litigation started --
A. That's --
Q. -- concerning the issues of degradation found in explanted prolene devices or opinions concerning pathological findings concerning explanted prolene devices, correct?
MR. VOUDOURIS: Objection; compound, form, foundation, and asked and answered.

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A. As I mentioned to you, I think you are repeating this question multiple times. I already answered that.
Q. (BY MR. THORNBURGH) But my question was: Before this litigation started -- let me strike that.
Did you -- have you talked to any of Ethicon's employees?
A. I don't think I talked to any Ethicon employee.
Q. So in -- in reaching your opinions today, you didn't reach out to any of Ethicon's employees to discuss with them what their findings were concerning degradation observed in explanted prolene devices?
MR. VOUDOURIS: Objection. Again, the agreement is that this is a Corbet fact specific deposition. He was already asked this lines of questions in his Husky and Edwards deposition.
A. And, again --
MR. VOUDOURIS: So you've already -- Doctor, you've already addressed those questions in prior depositions.
Q. (BY MR. THORNBURGH) Concerning your opinions in this case, Ethicon did provide to you at least one internal Ethicon document, right?
A. Yes.

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Q. And if they had additional internal Ethicon documents concerning observations and conclusions that explanted prolene devices degraded, it wouldn't matter to you because you don't rely on the internal documents of other Ethicon scientists?
MR. VOUDOURIS: Objection; asked and answered.
Go ahead.
A. As I mentioned to you, I'm a pathologist. I mainly rely on whatever the material I have, such as slides I received for this case. That's the most important thing, all right. Then also, I use routine microscope the pathologists are using every day for their practice to examine what in the slide. Then report candidly about what the finding from the slide. That's my main duty, I think.
I have, also, the freedom -- yes, as you say, I'm paid for the deposition or my professional time, but I still -- I'm freedom to choose what is more important or more candid for me to represent, you know, this case, okay. It's not like you -- I'm paid, then you --
MR. VOUDOURIS: You've answered -- you've answered his question.
THE WITNESS: Okay.

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Q. (BY MR. THORNBURGH) Since you issued your report in this case, do you have an understanding that Dr. Iakovlev's study regarding explanted mesh devices has been published in the peer-reviewed articles?
A. I noticed that.
Q. Have you published any studies in the peer-reviewed articles concerning -- since your last deposition -- concerning your examination of explanted mesh devices?
A. Not yet.
Q. Are you planning to?
A. Yes. We -- because this -- I also feel this is a needed within the pathology -- surgical pathology field. Just like Dr. Smith's paper, they found approximately 50 percent of the cases not being processed properly. Therefore, there is a need in this field as a pathologist.
If they -- when they receive these specimen, they should know how to handle them in a standard way rather than just a random way. I think that's the reason we are planning to do.
Q. So let me try to understand exactly. Are you planning on writing a report -- or a publication similar to the Smith publication, or are you planning on publishing your opinions concerning your evaluation of

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explanted mesh devices?
MR. VOUDOURIS: Objection.
A. No, we are planning to just to provide information to the field, or to the general pathologists, let them be aware these specimens become more common, although they consider as their foreign body kind of material and people usually pay less attention for those specimens.
But these days, because of the importance in the field, then people -- pathologists should be aware how to handle these specimens, how to describe or what they should look for in the microscope in their practice. That's the purpose we are planning to do.
Q. (BY MR. THORNBURGH) Okay.
A. I'm not planning to do -- to -- specifically to address what Iakovlev's opinion and -- and my opinion. This is not relevant at all.
Q. Okay. So just to summarize, because that was a lot of information --
A. Right, right.
Q. -- since your report, Dr. Iakovlev has published his opinions concerning his observations of explanted polypropylene, including TVT, devices, in peer-reviewed publications, correct?
A. In the -- in the one article peer reviewed,

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yes.
Q. And what does it mean to be peer reviewed?
A. Peer reviewed can have many meaning. That means within the field. Then the editor of the journal will ask for one, two, or three reviewers to review what's the information in it.
Q. And that's because you want to make sure that the peer-reviewed allows for the publication of more reliable articles because the peers, your peers, review it and are critical when they review it, and determine whether or not it should be published, correct?
MR. VOUDOURIS: Object to form.
A. It's not necessary for that. Because I served as a co-chief editor for one of the professional journals recently. And we know within this process the authors are encouraged to submit the reviewer's name, because in every specialties, they -- they have some people they know are doing similar work. So therefore, there is a preference by authors who should review their articles. That's the process.
Therefore, this kind of process, although is still considered as a peer review, but it's not necessary all peer-reviewed articles. They are scientifically sound or they are just correct for their opinion. It still represent a group of the author's

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opinion.
Q. (BY MR. THORNBURGH) Okay. So let me make sure I understand that correctly. Number one, you're not suggesting in any way that Dr. Iakovlev somehow had -- had some -- strike that.
You're not suggesting that Dr. Iakovlev in this case, in publishing his -- his articles in the peer-reviewed journals that he published those articles, had some sort of input on who reviewed his article, are you?
A. This is a common process. I'm not sure what they have done in the process, but this is the common process. Every author or authors when they submit articles, they have a chance to suggest who will be the reviewers. Then, in many journals, they will follow these suggestions to pick up the reviewers.
Q. Okay. But you're not suggesting that that -- you don't have any basis or --
A. No.
Q. -- information to suggest that happened with Dr. Iakovlev's article, right?
A. That's why I say this in general.
Q. So in general, when -- so let's talk about that. In general, it's your understanding from your experience working in -- as a -- I think you said chief

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editor?
A. Yes.
Q. -- co-chief editor in a peer-reviewed journal that, unfortunately, publications -- articles can get published through a peer-reviewed process when -- when the author actually has some influence on who reviews the publication?
MR. VOUDOURIS: Objection; form.
A. Yes, this is correct.
Q. (BY MR. THORNBURGH) And that would include, for example, if Ethicon's key opinion leaders want -- wanted to publish their studies in a peer-reviewed publication under -- based on your experience, they could have some influence or input into who actually reviews their article before it gets published in the journal, correct?
MR. VOUDOURIS: Objection; form, foundation.
A. Author has this choice. However, journal editors has their own decision who should be asked for review. So these are the dual ways. It's not only one way.
Q. (BY MR. THORNBURGH) Journal editors such as yourself?
A. Right.

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Q. Who's a paid expert for Ethicon?
MR. VOUDOURIS: Objection.
A. What do you mean? Paid for -- expert for --
Q. (BY MR. THORNBURGH) You're an expert for Ethicon in the litigation, right?
A. The journal -- my journals, they -- we do not have any publications related to mesh yet so far.
Q. But in some circumstances, the authors have input on who reviews their publications and editors can veto a decision to have reviewers -- certain reviewers review an author's publication.
And in the current situation, you're an editor for a peer review publication and also an expert for Ethicon?
MR. VOUDOURIS: Objection; form, foundation, asked and answered, and very compound.
A. Yeah. I think that this is not really relevant.
Q. (BY MR. THORNBURGH) I'll withdraw the question.
A. Yeah. Not really relevant.
Q. This is a new position that you have, though, as a co-editor?
A. It's been for two years.
MR. THORNBURGH: I assume I can ask some

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questions about that if he wasn't a co-editor in the prior cases?
MR. VOUDOURIS: You can ask.
Q. (BY MR. THORNBURGH) What -- what peer-reviewed publication are you a co-editor for?
A. The journal name is American Journal of Clinical and Experimental Obstetrics and Gynecology.
Q. What do you mean by "experimental obstetrics and gynecology"?
A. That means within the ob -- obstetrics and gynecology field, all the studies related to the clinical side as well as experimental side, then we will accept if they have a good quality.
Q. In other words, if they apply some sort of -- strike that.
In other words, if their method was reliable?
MR. VOUDOURIS: Objection.
A. We have to review. That's why -- depending on the quality and what kind of study, what kind of method they use, study design, hypothesis, then the contents, then the results, then all these, you know, relevant informations. That's a complicated process. I don't think you want to understand.
Q. (BY MR. THORNBURGH) No; I'm not going to

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spend much time. Let me just -- let me try to see if I understand just briefly. So if I did an experiment, for example, and I experimented and I had one sample -- N equals one, right?
A. Right.
Q. If I had one sample and I reached a conclusion based on that one sample and sent it to you to be published in an article, would you have a problem with publishing an article that reaches conclusions based on an experiment that included only one sample?
MR. VOUDOURIS: Objection; form and foundation.
A. Usually, that will be rejected. I don't think many journals will accept based on a single sample, but we do have interesting case report. Case report, that's different issue.
Q. (BY MR. THORNBURGH) So -- and -- so for a peer-review publication, a study with N equals 1 -- I think I've read somewhere that you want to have at least three samples in an experiment in order for it to be considered reliable. Is that accurate?
A. No.
MR. VOUDOURIS: Objection; form, foundation.
You've answered his question.

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THE WITNESS: Yeah.
A. No.
Q. (BY MR. THORNBURGH) How's it not? I'm trying -- I'm just trying to understand.
A. No. This is a -- like a publication -- or receive a manuscript to be considered for publication is a -- is a long process. It's not that simple. I cannot use one minute or two minutes to explain to you the entire process. I think this is also not relevant for this case too.
Q. Fair enough.
Do you have an updated curriculum vitae?
MR. VOUDOURIS: It's on Exhibit 2.
A. Yes. I submitted that and also included in the thumb drive.
Q. (BY MR. THORNBURGH) So in -- for preparing for this deposition, approximately how many hours -- strike that.
In preparing for this case and re-reviewing the case, looking at the new articles, getting ready for this deposition, approximately how many hours do you have invested in this case since your invoice of last year?
MR. VOUDOURIS: Objection; asked and answered.

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MR. THORNBURGH: I don't think I asked how many hours.
A. I didn't estimate exactly, but I think approximately 15 hours.
Q. (BY MR. THORNBURGH) 15?
A. Approximately.
Q. And it looks like, according to the invoice that was produced on Exhibit Number 2, which we'll maybe mark later on as a separate exhibit, you've been paid in this case so far approximately $29,400. Does that sound about accurate?
A. That sounds accurate.
Q. And since that invoice, you've worked on this case for approximately 15 additional hours?
A. Right. Because it's only recently I've been noticed, you know, deposition starts.
Q. And the deposition notice is actually marked as Exhibit Number 1. If you can grab Exhibit Number 1 real quick. When was that notice sent to you -- or I'm sorry, strike that.
When was that notice -- what's the date of that notice?
A. I don't remember exactly what the date the notice. I think a couple -- starting from maybe a couple of months ago, I -- Andy sent me a note saying --

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asking me what is available dates, possible dates and --
MR. VOUDOURIS: Doctor, listen to his question.
Q. (BY MR. THORNBURGH) Yeah, my -- my question --
MR. VOUDOURIS: He asked -- he asked a different question.
Q. (BY MR. THORNBURGH) Yeah. My question is simply -- because you indicated you had -- since your invoice of last year, you had worked for about 15 additional hours on this case, and you said that you began that work after you received the deposition notice. And so my question to you was, well, what's the date of the deposition notice?
MR. VOUDOURIS: I think he was confused by your earlier question.
A. I don't -- don't remember when Andy --
Q. (BY MR. THORNBURGH) If you just look at page --
MR. VOUDOURIS: Doctor --
Q. (BY MR. THORNBURGH) If you look at page 2 of the deposition notice, it says November 13th, 2015. Do you see that on Exhibit 1, page 2? Do you need help? Right there on the bottom -- right there, see the last notation on that page, it says date?

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A. This is the notice for today's deposition, right?
Q. Yes.
A. And -- yeah, I mean, I guess this -- if you're asking -- you already know the answer. I don't know why you're asking me this question.
Q. Because I get to ask these -- these questions. For -- for good or for bad, I get to ask these questions.
So the date is November 13th, 2015. So the 15 additional hours that you put in this case since the invoice of last year, would that have all happened after November 13th of 2015?
A. Yeah. Mainly -- majority of the -- the work has been done, that's these, you know, days, basically. That's why I say some of these documents I really don't have time to go through.
Q. So the 15 hours is after November -- November 13th, 2015, right?
A. That's -- that's fair.
MR. VOUDOURIS: Objection.
A. In the -- yeah, in the last several days.
Q. (BY MR. THORNBURGH) Okay. And how much time -- how much of the 15 hours was spent on meeting with Ethicon's attorneys to prepare for this deposition?

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A. I think a couple of hours, you know, we met for that.
Q. Did you meet one -- one time, two times, more than two times? How many times did you meet in preparation for this deposition?
A. Last -- yeah, we have twice.
Q. Okay. So the first time you met was when?
A. That was last week sometime. I don't remember exactly. But then also yesterday.
Q. Okay. So the first meeting that you had in preparation for this deposition last week, how long did that meeting last?
A. Probably about one hour, one and a half hour.
Q. Okay. And then you indicated, I think, that you also met again yesterday?
A. Yesterday.
Q. And how long did you meet yesterday in preparation for this deposition?
A. Similar time.
Q. So one to one and a half hours?
A. Right.
Q. So you've -- you've met and prepared -- you met with Ethicon's lawyers in preparation for this deposition for approximately two to three hours?
A. Yes.

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Q. So if you worked 15 hours and you worked -- and you spent two to three hours preparing with Ethicon's lawyers, what was the rest of the time dedicated to?
A. Reading, write, and review my report and refresh my mind what plaintiff's expert has said, just Dr. Iakovlev's report in the Exhibition [sic] Number 5. So those are the time I spent.
Q. Have you read since --
MR. VOUDOURIS: Dan, I'm sorry. Do you want to go off the record for a second?
MR. THORNBURGH: Sure.
THE VIDEOGRAPHER: We're off -- we're off record at 10:52 a.m.
(Break taken.)
THE VIDEOGRAPHER: We're back on record at 10:57 a.m., beginning of Tape 2.
Q. (BY MR. THORNBURGH) In preparation for your -- strike that.
Have you read or reviewed any additional depositions in this case in preparation for your expert opinion -- in preparation for your deposition?
A. I read Dr. Smith's deposition.
Q. When did you read Dr. Smith's deposition?
A. I think the -- the first time was -- was last

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year before the -- this expert report was prepared.
Q. Okay. So you read it -- and I think it's -- I think you identified that as a deposition that you read --
A. Right.
Q. -- and you identified that in your expert report from last year. Since your expert report, have you read any additional depositions?
A. No, I -- I don't.
Q. How much in total have you been paid by Ethicon to serve as an expert in the Ethicon mesh litigation?
MR. VOUDOURIS: Objection.
A. I don't remember.
Q. (BY MR. THORNBURGH) Do you have an estimation?
MR. VOUDOURIS: Objection.
A. Frankly speaking, I barely pay attention to the money issues.
Q. (BY MR. THORNBURGH) Greater than $100,000?
MR. VOUDOURIS: Objection.
A. I don't think so.
Q. (BY MR. THORNBURGH) Around 100,000?
MR. VOUDOURIS: Objection.
A. My main work is my own work, all right? This

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is -- I don't rely on the expert witness as my main income, no.
Q. (BY MR. THORNBURGH) That wasn't my question.
A. I know. That's why I say -- I answered I don't remember exactly.
Q. Okay. But I'm entitled to a fair estimation. So do you think it's been about 80,000 to $100,000?
MR. VOUDOURIS: Objection.
A. Maybe after all these cases. Each case is about $25,000, something like that. I -- but I don't quote exactly, okay? This is the rough estimation.
Q. (BY MR. THORNBURGH) Okay. And so you've -- you've testified in the Husky, Edwards, and Lewis cases, correct?
A. Correct.
Q. And you're testifying in this case. So is that about $100,000?
MR. VOUDOURIS: Objection.
A. I'm not sure.
Q. (BY MR. THORNBURGH) Approximately? If it's -- if it's $25,000 per case?
MR. VOUDOURIS: Objection; asked and answered.
A. I'm not sure. That's why I said, okay?
Q. (BY MR. THORNBURGH) Have you consulted with

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Ethicon on any additional cases other than the four that we've mentioned?
A. I don't think so.
Q. Have you been disclosed as an expert witness in any other case where you've been retained by Ethicon as an expert other than the Lewis, Husky, Edwards, or Corbet cases?
A. I think I have disclosed whatever I have done for litigations or serve as expert witness, yes.
Q. Right. So is there any -- have you been disclosed as an expert in any cases other than the four cases that we've discussed today?
A. I have disclosed.
Q. Okay. What case -- what cases?
A. Like ovarian endometrio cancer case.
MR. VOUDOURIS: Doctor --
THE WITNESS: Right.
MR. VOUDOURIS: -- I'm sorry to interrupt. I'm just trying to help you. That's not the question he's asking you.
THE WITNESS: Right.
MR. VOUDOURIS: And you were already asked about the prior times you've served as an expert in other litigation when you were deposed in the Husky and Lewis deposition.

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Q. (BY MR. THORNBURGH) And I'm not going to go there. I'm just trying to find out if you've been disclosed as an expert in any other cases for -- for -- as an expert for Ethicon.
A. For Ethicon? I have -- whatever the case I received, I always disclosed what I have done. That's for sure.
Q. I -- let me -- so let me just try and clarify. So what disclosure means --
MR. VOUDOURIS: Dan, can I help you? I don't believe he's --
Q. (BY MR. THORNBURGH) Have you been identified as an expert witness --
MR. THORNBURGH: Go ahead.
MR. VOUDOURIS: Let me help you. I don't believe he's --
MR. THORNBURGH: You know the answer?
MR. VOUDOURIS: Yeah.
MR. THORNBURGH: Okay.
MR. VOUDOURIS: I don't believe he's been disclosed in other cases other than the ones he's mentioned.
Q. (BY MR. THORNBURGH) Okay. Have you consulted with any other mesh manufacturers?
A. No.

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Q. Since issuing your expert report, have you published any articles in any peer-review journals?
A. Not for mesh. Yes, I have -- every year I have more than 10 papers published.
Q. That was going to be my next question. So I think the answer is, yes, you've published since you issued your expert report. Is that fair?
A. Yes.
Q. Which you -- I assume you've -- is included in your updated CV, which is attached as Exhibit 2?
A. Yes. You can -- you can see it.
Q. And none of those like -- like prior to the -- this -- like prior to your expert report that you issued in this case -- strike that.
None of the new publications that you've authored or coauthored that have been published in peer-reviewed articles since your expert report relate to mesh, correct?
A. Correct.
Q. And none relate to the TVT product?
A. Correct.
Q. And you have no intention of publishing in peer-reviewed articles concerning your work as an expert in these cases, right?
A. I don't have intention to use these material for publication. That's for sure. But I do have plan, together with my students, to summarize the mesh specimen related to the surgical pathology practice.
Q. And that's what we discussed earlier?
A. Correct.
Q. Not a -- an article regarding your findings as a pathologist under the microscope, but rather, recommendations to the community about doing microscopic examinations of explanted mesh devices?
A. Correct.
Q. And when do you plan on publishing that?
A. We don't know because everybody's so busy, lots of things going on. So as soon as we have adequate -- manage to be ready, then we are ready.
Q. Is the manu -- has the manu -- strike that.
Have you began to write the article?
A. Not yet. We're still collecting the data.
Q. Okay. So there's no draft of any --
A. No.
Q. -- form?
And so right now, you and your students are collecting data?
A. Correct.
Q. What types of data are you collecting?
A. It's explanted mesh material.

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Q. So are you --
A. Mesh specimens.
Q. Are you actually collecting mesh specimens?
A. No. We only examine the slides already existed or the samples received in the department of pathology in the University of Arizona.
Q. All right. So let me just try to understand this. So you're collecting data, and the data that you're collecting are slides that are available -- pathology slides that are available at Arizona University --
A. Uh-huh.
Q. -- or University of Arizona. But you have no intention of analyzing those slides and publishing your findings -- your pathological findings concerning that analysis?
MR. VOUDOURIS: Objection; form.
Q. (BY MR. THORNBURGH) Because I thought earlier you testified that you had no intention of -- I think I understand. So you have no intention of publishing your findings based on your review of mesh devices that you've looked at in the context of this litigation?
A. No, I'm not planning to do that, because this is --
MR. VOUDOURIS: You answered his question.

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A. Yeah, I already answer this question.
Q. (BY MR. THORNBURGH) So -- so do you plan on publishing your findings from your review of explanted pathology specimens that you're currently collecting from the University of Arizona?
MR. VOUDOURIS: Objection; form.
A. As I say, we are planning to publish or summarize the data regarding mesh specimen received in the past five years in the University of Arizona, which may be useful for the surgical pathology field. How to handle the specimen correctly, how to describe -- or what the kind of features that a pathologist should look for. Those are the information will be useful for the field.
Q. (BY MR. THORNBURGH) Okay. So when you say you're going to summarize the data, you're talking about your analysis of the pathology material at the University of Arizona, right?
MR. VOUDOURIS: Objection; form.
A. Yes; based on the pathology material there.
Q. (BY MR. THORNBURGH) And, currently, you're collecting the data?
A. Currently, we are collecting the data.
Q. Have you determined how many explant specimens are available at Arizona for the five-year period?

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A. Yeah. We estimated the total -- we did a search after our approval. We have a total of approximately 150 cases.
Q. Total of 158 cases?
A. -50, 1-5-0.
Q. 150 cases. And this is a single institution at the University of Arizona?
A. Correct.
Q. Is it the pathology department at the University of Arizona?
A. Yes.
Q. And are you a pathologist at the University of Arizona?
A. I was there for 10 years.
Q. Are you still there?
A. Recently, starting from July 1st of this year, I relocate to UT Southwestern.
Q. And are these pathology -- strike that.
So the pathology material that is being collected, 150 or so that have been identified, are those specimens -- have -- strike that.
Have you previously analyzed those specimens as an employee of University of Arizona?
MR. VOUDOURIS: Objection.
A. Majority of these cases, I sign out the

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reports.
Q. (BY MR. THORNBURGH) And for the majority of those cases that you sign out the reports that you've done in the past -- and I think you described this earlier when we talked about the Smith article, that most pathologists report on their macroscopic observations. Is that accurate?
A. Some of them, yes.
Q. Okay. And so of the 100 -- of the majority of the 150 that you've looked at in the past and have issued -- or signed out on the reports, was that based on macroscopic or microscopic observations?
A. I don't know how many they are macroscopic only, but if macroscopic only, we will just record a number. And all the findings will be based on microscopic findings.
Q. For the 150 at Arizona, you wouldn't have to necessarily go -- strike that.
When you were working for the University of Arizona as a pathologist and you were signing off on the reports, is it fair to say the majority of those reports that you signed off on were based on a macroscopic observation of the explant material?
A. No.
MR. VOUDOURIS: Objection.

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A. Mainly -- majority of such cases based on, they do have microscopic slides prepared.
Q. (BY MR. THORNBURGH) I know they may have -- so they have microscopic slides prepared. Does that mean they were actually analyzed by you or another pathologist microscopically, or were the reports signed off based on a macroscopic observation?
MR. VOUDOURIS: Objection.
A. Majority of them based on both macroscopic as well as microscopic.
Q. (BY MR. THORNBURGH) So is it fair to say -- is -- is it your understanding that, like the Smith article, perhaps, that 50 percent were microscopic and 50 percent were macroscopic?
MR. VOUDOURIS: Objection.
A. Things are different, because our institution, things -- starting from, I think, two to three years ago, we have noticed those situations in the entire medical field, so therefore, I was asked to provide standard protocol how to handle these specimen.
Then -- since then, every specimen, if the specimen -- the size is larger than two centimeters, then half of them will be processed for microscopic examination.
Q. (BY MR. THORNBURGH) Okay. So a lot of

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information. And this is why your -- why you decided to do an article -- publish an article on it and working with your students. So let me just try to figure out.

About two to three years ago, you drafted the protocol on how to handle specimens?

A. Correct.

Q. Okay. Have you produced that protocol in any of these cases yet?

A. We did not publish, because it's like internal guideline for our pathologists. And also, we have -- in the University of Arizona, we have risk management office. They were involved for some of those cases, because they -- it's labeled as a legal case, so therefore, they have to save the -- some of the specimen into the risk management office.

Then, that cause lots of problem, because the pathologist department -- pathology department is responsible to release pathological finding. And if they are -- they want to help -- hold these cases, then we are not able to issue the report. So therefore, we all came together, then came out as a general consented guideline. I'm the main person to provide this guideline --

Q. Okay.

A. -- because I was -- I was the GYN pathologist

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there.

Q. Okay. So my question was: Has that written protocol been produced in any of the cases -- litigation cases to date?

A. It's -- all these litigation cases today is not from University of Arizona, therefore, it's not relevant.

MR. THORNBURGH: We want -- I want a copy of the protocol from the University of Arizona that he drafted and -- which serves as a protocol for how to handle mesh specimen explants.

MR. VOUDOURIS: I don't know if I have any control over what the internal department at the University of Arizona says and whether they're IRB and HIPAA implications --

THE WITNESS: Right.

MR. VOUDOURIS: -- so I can't answer that question.

MR. THORNBURGH: I'll send a follow-up e-mail requesting it.

Q. (BY MR. THORNBURGH) And just to follow up on some other things that you said, you were the -- sorry. Strike that.

So you test -- just testified that the risk management office was involved in some of the

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pathology specimens that were received at the University of Arizona because some of those cases were labeled as legal -- legal cases, correct?

A. Yes.

Q. So the specimen goes to the risk management office at that point?

MR. VOUDOURIS: Objection. If you know.

A. Yes. Some of them, they go, then that's why I say because these are conflicts. If risk management has all the specimens, then department of pathology has no specimen, then no report is going to be issued. Therefore, the clinician is concerned, and then pathology department also is concerned.

And -- because they send to us and we don't have report, therefore clinician, risk management office, and pathologist all come together and have a consensus meeting how to handle these specimens. Then I generate this guideline.

Q. (BY MR. THORNBURGH) Okay. And so did the guideline somehow -- I assume based on what I think I understand from your testimony, the guideline established that half of the specimen would be divided and kept at the University of Arizona risk management department, and then the other half would be analyzed by you or other pathologists?

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MR. VOUDOURIS: Objection.

Q. (BY MR. THORNBURGH) And that was for the legal -- the legal cases?

MR. VOUDOURIS: Objection.

A. Yeah, yeah. If you really want to know the content, I think because I'm the person write this one, I can tell you the basic components, all right? The basic thing is if the specimen is larger than two centimeter in size, all right, then we will cut half for histological examination process. Then the remaining half will be saved in the formalin and will be delivered to the high risk -- or risk management office, number one.

Q. (BY MR. THORNBURGH) To -- sorry, go ahead.

A. Number two, if the specimen is smaller than two centimeter in size, then no histological section will be done because it's for legal purposes. Then the entire specimen will be delivered to the risk management office.

Q. Okay. So I think I understand all -- so let me just figure it out, just make sure I understand it. And you're -- you were the person that oversaw this change in the process at the University of Arizona, right?

A. Correct.

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Q. And that was two to three years ago?
A. Yes.
Q. And that was while you were serving as an expert for Ethicon?
A. No. I don't think that's the -- that's the reason. Because I -- I'm the --
Q. That wasn't -- my question wasn't, was that the reason? My question to you was: When the protocol changed, based on your recommendations, you were an expert for Ethicon?
MR. VOUDOURIS: Objection; form.
A. That's not related, because --
Q. (BY MR. THORNBURGH) It's a yes-or-no question, though.
A. Yeah.
Q. I mean, were you an expert at the time for Ethicon?
A. At the time, I was, but this was not the reason because I'm the expert for Ethicon, then I will provide -- volunteer and provide this guideline. No. Because I am -- I was the chief of the GYN pathology there, then in handling all the GYN specimen, including mesh specimen --
Q. Okay.
A. -- okay?

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Q. Hold on. So my question was simply: At that time, when you changed the protocol, you were an expert of -- for Ethicon? That's my only question.
MR. VOUDOURIS: Objection; form, foundation.
Q. (BY MR. THORNBURGH) So the answer to that question is yes, right?
A. Yes.
MR. VOUDOURIS: Objection.
Q. (BY MR. THORNBURGH) And so -- so if I had a legal case, all right, my client had a mesh specimen of two centimeters that was available at the University of Arizona, and I sent a request for preservation of the two centimeter sample -- explant sample so that it could be evaluated for purposes of litigation, the protocol that you established would actually send for litigation purposes only one centimeter to be analyzed?
A. If it --
MR. VOUDOURIS: Hold on.
Q. (BY MR. THORNBURGH) Let me -- let me -- let me -- let me ask again. I'll withdraw that line of questioning and let me get it down.
So two to three years ago, as an expert for Ethicon, you changed the protocol such that if I had a case -- I had -- I had -- I represented a client whose

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mesh was explanted and sent to the pathology department of the university that was greater than two centimeters, and I sent a preservation letter to preserve that evidence for purposes of litigation, you would first divide that specimen and keep it and analyze it at the University of Arizona and send the other half for litigation -- for -- to the risk management for hold?
MR. VOUDOURIS: Hold on.
Q. (BY MR. THORNBURGH) Right?
MR. VOUDOURIS: Hold on. I gave you leeway to ask questions about this. This has absolutely nothing to do with the fact specifics of Corbet. You have asked tons of questions about it that has nothing to do with Corbet. And I --
MR. THORNBURGH: He's -- he's offering this testimony.
MR. VOUDOURIS: Well, I'm telling the doctor --
MR. THORNBURGH: I'm just following up on it.
MR. VOUDOURIS: This has nothing to do with Corbet. He's asked -- he's answered plenty of questions on this topic, so let's get to the fact specifics of Corbet.
MR. THORNBURGH: I mean, I think, in all

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fairness, he -- he offered that -- that -- that information voluntarily. I get to follow up on it and say, you know, if I send -- if I -- if my -- if I send a preservation letter to the University of Arizona for a specimen that was explanted from my client and there's two centimeters, I don't get the full explant to be analyzed?
MR. VOUDOURIS: It has nothing to do with the fact --
MR. THORNBURGH: I think that's important.
MR. VOUDOURIS: It has nothing to do with the fact specifics of Corbet.
MR. SNOWDEN: If you want to pull out an Ethicon preservation notice which tells the hospital to follow their standard procedures, why don't you show him that?
MR. THORNBURGH: That's something we'll take up at a later time.
Q. (BY MR. THORNBURGH) How much -- in Mrs. Corbet's case, how much mesh was explanted?
A. I think I have a gross description about the slides and the specimen I received.
Yes. I said I received the following material labeled as Kathryn Corbet. And then date of surgery, that was February 19, 19 -- 2013. And the

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first batch includes three H&E slides and two unstained slides.
All right. Then the slides labeled as A1, B1, and C1. Then slide C1 represent ex -- excised mesh. Now, A1 and B1 were from bladder biopsies. The second batch of the slides include five H&E and four corresponding S-100 staining with was one positive control, and the four masson trichrome stained slides and one positive control. So those are the material I received.
Q. Okay. And that's the material that you received from -- after Mrs. Corbet had her explant --
A. Correct.
Q. -- from -- at the University of Pennsylvania Health System?
A. Yes.
Q. Do -- do you know anybody -- any -- any pathologist who work at the University of Pennsylvania Health System?
A. Personally, I don't know any pathologist there, but they must have large amount of pathologists there.
MR. VOUDOURIS: He just asked you if you knew anyone at the University of Pennsylvania pathology department.

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A. Yeah, personally, I don't know anyone as a -- as a collaborator or -- or friend, no.
Q. (BY MR. THORNBURGH) And we're going to get into the -- the records here pretty soon, but -- in greater detail. But do you know what a consensus -- consensus conference case is?
A. Consensus conference means a group of pathologists read certain case together, get a consented opinion. That's a consensus conference.
Q. And do you do a consensus conference -- or did you do a consensus conference at the University of Arizona?
MR. VOUDOURIS: Objection.
A. We do -- we do all the time, but mainly for cancer cases as well as for difficult cases or unusual cases.
Q. (BY MR. THORNBURGH) And when -- in your experience when these consensus conferences take place, is there documentation created that discusses the consensus reached by the pathologists who reviewed the pathology material separate from the pathology report that's signed by the pathologist?
MR. VOUDOURIS: Objection.
A. Okay. Within the consensus meeting, generally, there is a sheet. All the pathologists

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present will be recorded. Therefore, they're reviewing -- one pathologist will present his or her cases. Then the remaining pathologists will render their opinion, either agree or provide different interpretations, then, finally, people will get a consent.
Q. (BY MR. THORNBURGH) Have you participated in a consensus conference before?
MR. VOUDOURIS: Objection.
Q. (BY MR. THORNBURGH) Since -- how about since your last deposition, have you participated in a consensus?
A. Every week, we have that.
Q. Have you participated, since your last deposition, in a consensus conference case regarding a mesh explant?
MR. VOUDOURIS: Objection.
A. There -- there is no -- no need for mesh to be considered for a consensus, because this is not considered as a complicated case or difficult case.
Q. (BY MR. THORNBURGH) That wasn't my question, though. My question was --
MR. THORNBURGH: So move to strike.
Q. (BY MR. THORNBURGH) My question was pretty simple. As -- since your deposition, have you served on

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a consensus panel concerning the analysis of explanted mesh material?
MR. VOUDOURIS: Objection; asked and answered.
MR. THORNBURGH: And the answer is yes or no. I mean, he -- he didn't answer the question.
A. I answered no.
MR. VOUDOURIS: He said there's no need to.
A. I also give you the reason why no, because there is no reason to have any hospital -- so far, based on my understanding -- to review the mesh material in the consensus conference. I can guarantee you.
Q. (BY MR. THORNBURGH) It appears from -- from your --
A. Except for some complications or for other reasons. In general, there is no need at all.
Q. Does it appear from your review of the pathology report from Mrs. Corbet's explant that there was a consensus conference concerning her explant material?
A. I don't think I have written something like that. Can you show me where it is? Or we may have some misunderstanding there.
(Sotto voce conversation.)

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(Exhibit Number 6 was marked.)
Q. I'm going to mark as Exhibit Number 6 and we're going to talk about this throughout the deposition, but this -- I'm handing you Exhibit Number 6, which is from the pathology department at the Pennsylvania hospital. There you go.
MR. VOUDOURIS: Do you have an extra copy?
MR. THORNBURGH: I'm sorry, Counsel. I didn't do that on purpose.
(Witness reviewed document.)
Q. (BY MR. THORNBURGH) And if you turn in Exhibit Number 6, if you turn to Bates number ending in -08. Are you there?
A. Yes.
Q. And do you understand -- you understand that you're looking at the -- do you recognize that you're looking at the pathology --
A. The pathology report from the University of Pennsylvania Health System.
Q. Okay. And you see --
A. You highlighted specimen C, right?
Q. Did I highlight that? I gave you the wrong copy, I'm sorry. Can I get that back?
A. That's okay.
MR. THORNBURGH: I'll re-mark it.

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MR. VOUDOURIS: For the record, this document says case conference -- consensus conference case, but it doesn't reflect which specimen, A, B, or C, was part of the consensus conference case.
MR. THORNBURGH: I appreciate the speaking objection.
MR. VOUDOURIS: Does this exhibit have any highlighting of yours in it?
MR. THORNBURGH: That does not.
Q. (BY MR. THORNBURGH) So my question is, you see on page Bates number ending in -08 of Exhibit Number 6 under the file -- final diagnosis, it says consensus conference case?
A. Which sentence says that?
Q. Under -- under final diagnosis C, eroded vagina mesh.
MR. VOUDOURIS: Objection.
A. The gross description or microscopic -- okay. Consensus conference case, okay. All right.
MR. VOUDOURIS: There's no question. He just asked you if you saw it.
A. I see it, but can I explain to you?
MR. VOUDOURIS: Hold on. He just asked you a question and you answered it. Wait for the question.

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THE WITNESS: Okay.
Q. (BY MR. THORNBURGH) Do you see where it says consensus conference case?
A. I saw that.
Q. Would that indicate to you that the mesh or other explant tissue material that was removed from Mrs. Corbet's body was looked at by multiple pathologists during a consensus conference?
MR. VOUDOURIS: Objection; form, foundation.
A. Here, consensus conference case usually indicate part of the specimen as being reviewed in the -- in this consensus meeting, okay? Part of the specimen. All right. It's not a very good way to record in the very vague way, say consensus conference case.
Typically, people will say which specimen has been reviewed in that consensus meeting, and then what kind of opinion or consensus opinion has been reached? That's a typical way of a more -- it's a better way to describe, rather than just say consensus conference case, okay.
Then, for this case, we have three specimens, right, A, B, and C. Only C is the mesh specimen. A and B -- between the B specimen -- in the B

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specimen, you have a urothelial papilloma, which is considered as a small benign tumor, okay? Then, for some --
Q. (BY MR. THORNBURGH) That's -- strike that -- well, excuse me. I don't mean to interrupt, but small benign tumor, is that what you said, papilloma?
A. Yes, uh-huh.
Q. That's nothing serious, right?
MR. VOUDOURIS: Objection.
Q. (BY MR. THORNBURGH) Nothing significant?
MR. VOUDOURIS: Objection.
A. Well, if it is true, it's nothing serious. However, if for some inexperienced pathologist, or the pathologist who does not have much experience about this diagnosis, then they will show in the consensus meeting, and then try to get confirmation of the diagnosis. That's usually the case. If you want to confirm whether this is correct, then you can call the pathologist, what does it mean, and they will explain to you in detail.
Q. (BY MR. THORNBURGH) Okay. So let me ask you this: In a consensus conference case, does the pathology -- final pathology report get issued before or after the conference?
MR. VOUDOURIS: Objection; form --
A. Because pathology report --

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MR. VOUDOURIS: -- and foundation.
A. Pathology report almost always released after consensus meeting.
Q. (BY MR. THORNBURGH) So is it your understanding, based on your review of the pathology report, that this pathology report most likely was submitted after the consensus conference took place?
MR. VOUDOURIS: Objection; form, foundation.
A. Yes, this is usual case.
Q. (BY MR. THORNBURGH) And according to the pathologist -- or the pathology report, which is marked as Exhibit Number -- within -- contained within Exhibit Number 6 and found on the -- the final diagnosis found on 00009, "The consensus was skin and fibroadipose tissue with mesh and associated foreign body giant cell reaction and chronic inflammation" [as read]?
MR. VOUDOURIS: Objection; form and foundation.
A. The consensus conference case in the last line for this report does not specifically indicate this is for specimen C, okay? It is just only indicated this case, all right, somehow has been just gone through the consensus meeting. That's my understanding.
It certainly does not indicate the mesh

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is -- just goes through the consensus meeting. Because I can guarantee, all right, in United States not -- I can say majority of the pathologists is not going to show the mesh around to say, okay, do you recognize this as mesh material? No. There's no meaning for a pathologist usually, right? They just describe what they --
MR. VOUDOURIS: You've answered his question.
Q. (BY MR. THORNBURGH) The -- the -- you would agree with me that, in any event, number one, under the eroded and vaginal -- eroded vaginal mesh, final diagnosis, it says consensus conference case, right?
MR. VOUDOURIS: Objection --
Q. (BY MR. THORNBURGH) That's what it says?
MR. VOUDOURIS: Objection; form, foundation.
Q. (BY MR. THORNBURGH) That's where it appears on the pathology report, right?
A. It -- it's on the pathology report, it's obvious.
Q. And the conclusion regarding the foreign body and chronic -- and -- and inflammatory response identified on this pathologist -- pathology report from Mrs. Corbet's explant indicates that the mesh was

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associated with foreign body giant cell reaction and chronic inflammation, right?
A. Yes. That's always the case.
Q. It doesn't say mild, right?
MR. VOUDOURIS: Objection.
A. You can read. It does not -- it's not there. People -- if that's why --
MR. VOUDOURIS: You've answered his question.
Q. (BY MR. THORNBURGH) It doesn't say mild inflammatory response, right?
A. Based on this report.
MR. THORNBURGH: I've got to take a bio break.
THE VIDEOGRAPHER: We're off record at 11:39 a.m.
(Break taken.)
THE VIDEOGRAPHER: We're back on record at 12:43 p.m.
Q. (BY MR. THORNBURGH) Doctor, did you have a good lunch?
A. Yes. Thank you.
Q. Okay. Good.
Doctor, I just want to circle back to a couple of things that you testified to before we went on

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our lunch break. One of the things you'd indicated -- I'm not going to go into great detail and re-ask these questions, but one of the things you indicated was that you were developing -- or wanted to develop a protocol or to find a protocol in the publication that you're planning to publish?
A. Yes.
Q. Okay. And does that include a protocol for grading your pathological findings?
MR. VOUDOURIS: Objection.
Go ahead.
A. I think we are planning to generalize those guideline for all -- for majority of the surgical pathologists to -- who is going to encounter or receive these specimens, how to handle them, number one, grossly and microscopically.
And microscopically, yes, we will illustrate what are the most common findings they should describe, such as -- include -- data will include information -- amount of information or the degree of information, that's true.
Q. (BY MR. THORNBURGH) And does part of that protocol include grading the degree of, for example, inflammation on some sort of scale?
A. Yes. We are going to put mild -- no

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information will be 0, mild will be 1, moderate will be 2, then severe or marked will be 3. Those are typical grading system being used in the general surgical pathology practice.

Q. And within each one of those subgrades, do you -- are you -- do you plan on providing some type of guideline based on your -- or the morphological findings under the slide, for example, if you see a certain amount of neutrophils, you get a certain grade, or if you see a certain amount of giant cells, you get a certain grade for -- is that how it works?

A. Yes. I think this is -- will be very much similar to Hill's paper I already described.

Q. Have you already created or drafted the protocol?

MR. VOUDOURIS: Objection.

A. No.

MR. VOUDOURIS: Asked and answered.

Q. (BY MR. THORNBURGH) Did you -- did you -- so you didn't use that type of grading system in your evaluation of Mrs. Corbet's explant material, correct?

MR. VOUDOURIS: Objection.

A. In -- for Mrs. Corbet's case, I have described based on my findings, yes. I used a grading system.

Q. (BY MR. THORNBURGH) Is the reason why you --

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you're developing this protocol, want to publish this protocol, to provide objective criteria so that the pathological findings are less subjective?

A. Correct.

Q. So the grading, for example, for inflammation or the inflammatory response based -- based on the number of inflammatory cells that are present in a microscopic slide?

MR. VOUDOURIS: Objection.

A. Yes. Based on the number, then the -- the extensiveness and the locations -- close -- the relationship with the mesh fiber spaces.

Q. (BY MR. THORNBURGH) And how do you determine the extensiveness of the inflammatory response? Is that also based on the number of inflammatory cells present in the slide?

A. Usually we will enter lower power, for instance, 4X, and then we will see how many foci of these inflammations will be localized within the slide. That's so-called extensiveness.

Q. So you'll see the -- you'll use 4X, and that's the magnification?

A. That's usually -- 4X, sometimes, yes. In a -- in a scanning situation, you use -- we use lower power. Then, if -- when we want to confirm these are

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inflammatory cell or not inflammatory cell, then we will turn on a high power to confirm.

Q. So at first, you start with a 4X power?

A. Typically.

Q. And you scan the entire specimen?

A. Correct.

Q. And -- and look for the morphological features of the specimen?

A. Correct.

Q. Like the number of inflammatory cells?

A. Correct.

Q. Like the number of foreign body giant cells?

A. Correct.

Q. Or multinucleated giant cells?

A. Giant cells, that means multinuclear giant cells.

Q. And the purpose of that is to create an objective way to grade rather than a subjective analysis?

A. Correct. And if in the long-term run, if many such findings accumulate, then these data can be analyzed together.

Q. And you -- I think you said that your -- the criteria is essentially based on the guidelines discussed in the Hill article, right?

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MR. VOUDOURIS: Objection.

A. It's not based on, because this is a general -- in general practice, within the pathology, people use these criteria to describe. That's so-called semiquantitative method. It's not exact quantitative. Semiquantitative method.

Q. (BY MR. THORNBURGH) And so I'm just trying to understand. Are you saying that the authors -- that the -- that the people that published -- the doctors that published the Hill article called histopathology of excised midurethral -- urethral sling mesh use a semiquantitative method?

MR. VOUDOURIS: Objection.

A. Yes.

Q. (BY MR. THORNBURGH) And in your guidelines that you want to publish, how would you define mild inflammation?

MR. VOUDOURIS: Objection. Counselor, we talked about his protocol this morning. We've already discussed that your deposition today is Corbet fact specific. You have gone far afield of that. I've given you a leeway.

MR. THORNBURGH: I'm -- I'm not trying to.

MR. VOUDOURIS: But you have. And -- and let's stop and let's move on, and let's ask about fact

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specific Corbet topics.
MR. THORNBURGH: Well, I'm tying this all into the fact specific. My -- my question is absolutely related to Corbet.
MR. VOUDOURIS: How so?
MR. THORNBURGH: Because I want to know -- because you're going to find out, but I want to -- I want to know --
Q. (BY MR. THORNBURGH) Let me ask you this question: You didn't use -- is it fair to say that you did not use the criteria that was identified -- or the guidelines -- grading guidelines that were used in the Hill article in your evaluation of Mrs. Corbet's pathology slides?
MR. VOUDOURIS: Objection, compound.
A. Hill article published it this year, right? And that's why I say the grading system -- or semiquantitative grading system for the amount of inflammation is generally accepted within the pathology field. That's the criteria I'm using, and also many other pathologists are using if they want to use -- to grade the amount of inflammation.
Q. (BY MR. THORNBURGH) Okay. So is that the criteria that you used in your evaluation of Mrs. Corbet's pathology?

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A. Correct.
MR. THORNBURGH: That's why I'm trying -- that's why I'm asking these questions.
Q. (BY MR. THORNBURGH) And so how -- using that criteria, how many inflammatory cells identified in the -- a single mesh specimen would lead you to conclude that the inflammatory response was mild?
MR. VOUDOURIS: Objection, again, that is not case specific to Corbet.
MR. THORNBURGH: He said -- he said that he used this in the Corbet case, so I'm trying to figure it out. I don't know how that's not specific to Corbet.
THE WITNESS: Should I answer?
MR. VOUDOURIS: Go ahead.
THE WITNESS: That's not a big issue.
A. Mainly, as I said, this is -- first of all, this is semiquantitative method, okay? The amount of inflammation or the degree of inflammation is not based on pure number of the inflammatory cells, all right? That's so-called semiquantitative.
We see amount of in -- inflammation surrounding certain area. If they sparse, only few, small amount in the lower power, then confirm in the higher power, then that's considered as a mild or even minimal. Minimal, mild is basically the same, okay?

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If there is basically no easily identifiable inflammatory cells, then we will classify it as no information. And if we see clusters of these inflammations relatively easily identifiable surrounding the mesh fiber spaces, then we will say that's moderate, all right, in addition to some of these giant cells. Then, if we see huge amount of accumulation of inflammatory cells, all right, in large amount of area, then we say that's a severe or marked. That's so-called a semiquantitative grading system.
Q. (BY MR. THORNBURGH) Okay. And so I'm just trying to understand how you applied it to Mrs. Corbet's case. When you say "sparse," what does that mean specifically?
A. Shall I show you pictures I have?
Q. No. I'm just -- I'm just talking --
A. Right. Then within the picture, then you can see much better. Otherwise, we are talking -- when I describe I have picture in my mind, but you are not pathologist, you don't understand what I'm talking, so we are making circles. So the best thing is pointing with a picture, I can show you what -- exactly what I mean.
Q. We're about ready to go through -- we're going to go through your entire report, case specific

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report --
A. Okay.
Q. -- here in a moment.
But is it fair to say that -- that -- that an individual pathologist's definition of sparse -- or observation of sparse inflammatory cells is still subjective, or is there a -- is there -- are there objective criteria that lead to a conclusion that the inflammatory response -- inflammatory cells are sparse?
MR. VOUDOURIS: Objection.
A. There is variation, that's for sure. Because a semiquantitative method, all microscopic observation, there is certain degree of variation. That's for sure, okay. But more or less, in general, people agree on.
Q. (BY MR. THORNBURGH) Are -- is there a different method than semiquantitative?
A. There is no definitive method except some people like to use, like, immunohistochemical stainings. For instance, like a CD68 can identify the number of inflammatory cells.
But still even though they use immunohistochemical stainings, then overall is not going to count the individual cells, how many cells, give you a specific number. Still give you ballpark, roughly, amount how much is mild or is moderate or severe.

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That's the situation.
Q. I think I understand.
A. Right.
Q. The other thing I wanted to circle back around on was, you said that you recently left your employment with the University of Arizona?
A. Correct.
Q. What was the reason for leaving University of Arizona?
MR. VOUDOURIS: Objection.
Go ahead.
A. UT Southwestern provides a better opportunity for my academic practice.
Q. (BY MR. THORNBURGH) Okay. So you're -- when did you leave University of Arizona?
A. That was July of this -- this year.
Q. Okay. And you accepted a position at UT Southwestern in July of this year as well?
A. Yeah. That's the --
Q. That's why --
A. Right.
Q. And what position did you accept at UT Southwestern? What's your current position there?
A. I'm a tenured full professor of pathology as well as obstetrics and gynecology. And then also, I

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have endowed distinguished professorship in UT Southwestern. Then I'm also the group leader as the chief of the GYN pathology group. Within this group, I have 10 pathologists involved.
Q. Now, in preparing to offer opinions in this case, what were you asked -- case specific, what were you asked to do -- what was -- strike that.
What did you do to come to your opinions -- case specific opinions in Mrs. Corbet's case? What did you review?
A. I reviewed the slides, reviewed the medical records, reviewed some depositions from surgeons, and then generated my idea -- or my opinion.
Q. Okay. So you reviewed the medical records, you reviewed the pathology material, and you reviewed depositions?
A. Right. And also including plaintiff's expert report, because I have to address those specific points.
Q. And did you attempt to correlate the clinical findings identified in the medical records to your pathological findings?
MR. VOUDOURIS: Objection.
Go ahead.
A. I tried, but from histological point of view, all the histological findings usually do not predict,

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you know, what exactly the clinical manifestation should be -- or would be -- in this particular case.
Q. (BY MR. THORNBURGH) You said most of the time. Are there -- is there any -- has there ever been a time that you have correlated your histopathological observations of an explanted mesh to the clinical findings discussed in medical records?
A. Oh, yes.
MR. VOUDOURIS: Objection.
A. Yes. In the past, for instance, if I found marked amount of inflammation, including pus formation within the specimen, then that's correlated to the clinical finding of infection. You know, those are situation.
Q. (BY MR. THORNBURGH) Since your last deposition -- I believe I read in one of your depositions that you're receiving one or two explant meshes per week for a period of time? I'm just trying to understand. Has that changed since your last deposition?
A. Still similar, when I was in Arizona.
Q. So when you were in Arizona up until the time you left, you were receiving on a weekly basis one to two mesh explants?
MR. VOUDOURIS: Objection.

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A. You mean -- you mean UT Southwestern or --
Q. (BY MR. THORNBURGH) Sorry. So -- you left Arizona in 2000 --
A. Yes.
Q. -- July of 2015?
A. Right.
Q. I think your last deposition was in --
MR. VOUDOURIS: April.
Q. (BY MR. THORNBURGH) -- 2000 -- April 2014. So was it consistent during that time period that you would continue to receive one to two explants --
A. Yeah.
Q. -- explant -- mesh explants per week?
A. Correct.
Q. And since April of 2014, have you received TVT mesh explants at your facility?
A. I can't be sure, because typically, in the pathology requisition sheet, they do not specify this is TVT versus any other types of sling. But they do indicate this is a mesh -- vaginal mesh specimen.
Q. Are there any -- have you -- in your experience, have you identified any morphological features of a mesh that could allow you to assume or conclude that the mesh explant was a TVT?
MR. VOUDOURIS: Objection. This line of

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questioning --
MR. THORNBURGH: I -- I -- yeah.
MR. VOUDOURIS: -- was already asked in his prior deposition.
MR. THORNBURGH: Okay. I -- I'm just trying --
Q. (BY MR. THORNBURGH) I mean, for the -- for the --
MR. VOUDOURIS: It already has.
Q. (BY MR. THORNBURGH) For the mesh that you've looked at in the last year that you've received on a weekly basis, did any of those contain blue fibers?
A. Oh, yeah. We -- many of such specimens have blue plastic piece.
Q. By "blue plastic piece," you mean the blue fiber?
A. Blue mesh filament.
Q. Since April of 2014, how many mesh explants have you received that have blue mesh filaments?
A. I don't know the answer because I didn't calculate.
Q. Majority?
MR. VOUDOURIS: Objection.
A. As I said, probably it's not a good idea to give you just estimation since I do not really count --

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you know, calculate how many exactly we have for those specimen contains blue mesh.
Q. (BY MR. THORNBURGH) And based on your review -- so let's talk about the medical -- Mrs. Corbet's medical records --
A. Sure.
Q. -- a little bit --
A. Sure.
Q. -- her medical history. Based on your review of Ms. Corbet's medical records, did you come to understand that she had a TVT mesh implanted in 2011 to treat stress urinary incontinence?
A. Yes.
Q. And did you -- also based on your review of her medical records, did you -- did you know -- did you come to understand that she had the TVT mesh explanted?
A. A year later. And before -- in the surgery, she also -- because she had prolapse, like cystocele and rectocele, and the prolapse repair surgery was done too at the same time.
Q. Yeah. So that was -- so during her implant procedure, she had a anterior colporrhaphy and a posterior colporrhaphy, right?
A. Posterior colporrhapy, right, uh-huh. Correct.

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Q. And in 2013, she had a mesh -- her mesh was explanted, correct?
A. Correct.
Q. And what was your understanding based on your review of the medical records and your reading of Dr. Smith's deposition, who explanted the mesh, what was -- what were -- what were the reasons why -- or the reasons for Mrs. Corbet undergoing the mesh explant?
MR. VOUDOURIS: Objection; compound.
Q. (BY MR. THORNBURGH) I'll ask a better question.
Based on your review of the medical records and Dr. Smith's testimony, what is your understanding for the reason for Mrs. Corbet having her TVT mesh explanted?
A. Because Dr. Smith found an area of mesh exposure.
Q. You did read the medical records and you did read Dr. Smith's testimony, right?
A. Right.
Q. She -- she testified there was more than that reason for the removal of the mesh ex -- of the TVT mesh, correct?
A. I think this is the main reason because exposure. Then patient also complained of pain. And

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then, you know, that was -- the common reason, if any doctor finding mesh exposure, this could be the indication to remove.
Because if you leave exposed the mesh in the body, then that will cause more, like, complications such as infection. Because vagina is environment exposed to outside and is -- is not, like, aseptic condition. So, basically, has a more chance to expose to bacteria as a contact. So that's the reason.
Q. Do you under -- I'm going to just see if I understand. Was it your understanding from reading the medical records and -- and Dr. Smith's testimony that the mesh was explanted as a result of both the mesh exposure and the -- her pain that she was experiencing?
A. I think that's the reason Dr. Smith explanted the part of the mesh.
Q. And did Dr. Smith also testify that another reason she explanted the mesh was because of the voiding dysfunction that Mrs. Corbet was experiencing after the mesh implant?
A. I was not aware of this.
Q. Based on your review of the medical records, did you come to understand that after Mrs. Corbet was implanted with the TVT device, at some point in time after the implant, she experienced void -- voiding

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dysfunction?
A. I think so, yes. Probably was true, but I did not pay that attention.
Q. Did you come to understand that after the mesh was implanted that Mrs. Way [sic] began to experience overactive bladder?
A. Yes. That's in the medical record, Dr. Smith did mention that. I -- that one, I remember that.
Q. Is it your understanding that overactive bladder and urge incontinence is the same thing?
MR. VOUDOURIS: Objection.
A. Not in my specialty. Overreaction probably somehow has some kind of urgency, more frequency for -- for voiding issue.
Q. (BY MR. THORNBURGH) You said overreaction?
A. Overreactive bladder syndrome, basically, right, you are talking about?
Q. No, not overreaction. I want to talk about overactive bladder disorder.
MR. VOUDOURIS: Objection.
A. Overreactive bladder is a clinical term. I'm not -- usually belong to urology, okay? It's not belong to obstetrics and gynecology, so I'm not expert for that part.
Q. (BY MR. THORNBURGH) My only question is:

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When you reviewed the medical records of -- of Mrs. Corbet, did you see from your review of those records that after the TVT device was implanted, that Mrs. Corbet was diagnosed with overactive bladder disorder?
MR. VOUDOURIS: Objection.
A. I noticed that this has been stated in the report.
Q. (BY MR. THORNBURGH) You don't have an opinion one way or the other, I assume, that whether or not the mesh caused overactive bladder?
MR. VOUDOURIS: Objection.
A. I don't have any opinion about this because that's outside of my expertise.
Q. (BY MR. THORNBURGH) So is it fair to say that you're not going to come and testify at trial and offer an opinion that Mrs. Corbet's overactive bladder dysfunction was or wasn't caused by the mesh?
MR. VOUDOURIS: Objection; asked and answered.
A. I think that's -- that -- yes, I'm not going to provide my opinion related -- regarding the relationship between the mesh implantation and bladder overreaction.
Q. (BY MR. THORNBURGH) And just for purposes of

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the jury and the ladies and gentlemen -- and the court, you did not perform a pelvic examination of Mrs. Corbet, correct?
A. Correct.
Q. Is it fair to say that you would defer to physicians who have performed a pelvic examination concerning their differential diagnosis of Mrs. Corbet?
MR. VOUDOURIS: Objection.
A. That's not my -- my expert field, because I'm a pathologist. I provided pathological finding, you know, opinion regarding what I have observed under the microscope.
Q. (BY MR. THORNBURGH) So is it fair to say that -- let me strike that.
You saw in Dr. Smith's testimony she testified that the cause of Mrs. Corbet's erosion and dyspareunia was the mesh. You saw that, right?
MR. VOUDOURIS: Objection.
A. I didn't see that.
Q. (BY MR. THORNBURGH) You didn't -- did you read the depo transcript -- the deposition transcript of Dr. Smith?
A. I -- I read the depo, but I did not see that kind of sentence saying Dr. Smith says dyspareunia is caused by mesh. However --

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MR. VOUDOURIS: Hold on. You answered his question.
Q. (BY MR. THORNBURGH) Dr. Smith is the medical doctor who was actually treating Mrs. Corbet's medical condition after mesh implantation, correct?
A. Yes.
Q. And you -- you are not going to criticize Dr. Smith's observations of Mrs. Corbet during her care and treatment of the plaintiff, correct?
A. There is no reason for me to criticize the commission's finding or description.
And -- but I think I want to clarify two things. One is if somebody or a patient who has mesh exposure, then exposed mesh may cause pain. That's reasonable. But if this -- any patient if complains of pain and then when they receive mesh implantation, there's no such relationship. Says anyone receive the -- because of the patient receiving -- or received mesh implantation, then she also complains of pain, then the pain is caused by mesh. That's two different issues. You understand what I'm talking?
So my understanding at the beginning, you were asking me if Dr. Smith made a statement, says Mrs. Corbet, the pain complain is caused by mesh. That's why I -- I say I did not see that. But if you

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are saying -- if -- but I do remember Dr. Smith already stated she -- clinically she found mesh exposed area -- or mesh exposure -- in the focal area of the vagina. That's the statement.

Q. Do you -- and then do you recall that she also testified that the mesh exposure caused Mrs. Corbet's dyspareunia or painful intercourse?

MR. VOUDOURIS: Objection.

A. I don't remember says this is the exact cause, the only cause for -- for her pain. But based on my understanding, yes, anything exposed, mesh, may be related to the pain, or it's uncomfortable feeling. That's a common sense.

Q. (BY MR. THORNBURGH) You -- and you're not going to come in and testify that Mrs. Way's [sic] dyspareunia wasn't caused from the mesh exposure; is that right?

MR. VOUDOURIS: Hold on. Objection. I think you keep saying Mrs. Way's.

MR. THORNBURGH: I'm sorry, Mrs. Corbet. I have a trial...

Q. (BY MR. THORNBURGH) For Mrs. Corbet, when you come and testify at trial, is it fair to say that you're not going to testify or offer opinions that her dyspareunia was not caused from her mesh exposure?

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MR. VOUDOURIS: Objection; form.

A. I think I'm going to provide my opinion based on the pathological findings I have found. Then there is no histological evidence for me to say, all right, this is the -- her dyspareunia complaining is caused by the histological finding I have observed. Is that clear?

Q. (BY MR. THORNBURGH) So let me just make sure I understand your opinions. If Dr. Smith, Mrs. Corbet's treating physician, testified that the mesh exposure was causing Mrs. Corbet's painful intercourse, are you going to suggest or opine at the -- at the trial that Dr. Smith was wrong?

A. That's totally different question. Dr. Smith's finding is a clinical finding. And my finding is a pathological finding. So my opinion will be based on the pathological finding, and I -- I'm not in the position to comment Dr. Smith's finding or statement is wrong or is correct.

Q. Did you find path -- did your -- strike that.

In your pathological evaluation of Mrs. Corbet's explant, did you identify evidence of mesh erosion?

A. I tried very hard, but I don't see a good evidence of mesh exposure or erosive site.

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Q. And what would a mesh erosion or exposure look like microscopically? What would -- what would be the features?

A. Classic feature for exposure or erosion is squamous mucosa on the top but disrupted, number one. Then just right underneath of this disruption area, we will see the mesh fiber just immediately underneath or just exposed in the disrupted area. Then -- and then usual -- typically, this area will be associated with more intense inflammation. That's the histological finding for mesh exposure or erosion.

Q. Similar question: What would be the pathological features of a mesh that was contributing to pain?

MR. VOUDOURIS: Objection. All of these areas of questioning were asked during his prior deposition, so, again, we're plowing the same field again.

MR. THORNBURGH: Well, I'm just trying to find out if any of those -- you know.

MR. VOUDOURIS: Dan, with all due respect --

MR. THORNBURGH: I -- I -- I'm not trying -- I'm not trying to plow the same field, so I'm not -- that's not --

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MR. VOUDOURIS: That field has been plowed.

MR. THORNBURGH: All right, let's do this.

(Exhibit Number 7 was marked.)

Q. (BY MR. THORNBURGH) I'll mark as Exhibit Number 7 the medical records from North Dover OB/GYN Associates. Did you review the records from North Dover OB/GYN Associates in preparation for your expert report?

A. I briefly went through that, because there's not really many pathological related things here. Yes.

Q. If you'll turn to -- in Exhibit Number 7, if you'll turn to Bates number ending in -23.

A. Yes.

Q. And you see this record is electronically signed -- turn the page to 24.

A. This one [indicating], right?

Q. Yes. If you'll turn the page, you'll see that it was electronically signed by Dr. Russell Harrell?

A. Uh-huh, yes.

Q. And you understand that Dr. Russell Harrell --

A. Who was the surgeon implanted the mesh.

Q. Okay. And so based on this record, what were the clinical symptoms that Mrs. Corbet was experiencing at the time that she saw Dr. Harrell on March 23, 2011?

A. She had grade 1 cystocele, grade 2 rectocele

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we mentioned previously.
Q. Okay. And if you look to the social history --
A. Social history?
Q. Yeah. Do you see that there on Bates number -23?
A. Alcohol use, drinks occasionally; and tobacco use, denies; then recreational drugs, denies; then diet, balanced diet; lifestyle, active lifestyle.
Q. Okay. So based on this record, which is -- which was recorded prior to her implant procedure, would you agree that -- that Ms. Corbet was not a smoker?
A. Looks like it.
MR. VOUDOURIS: According to the record.
A. According to the record.
Q. (BY MR. THORNBURGH) Not a smoker?
A. Yeah. According to the record, yeah.
Q. Did you see any evidence in any of the medical records that she was a smoker?
A. No.
Q. Okay. And she only occasionally drank alcohol, right?
A. Based on the record.
Q. And so smoking was not a risk factor for Mrs. Corbet with respect to erosion, based on your

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review of the medical records, correct?
MR. VOUDOURIS: Objection.
A. You are talking about individual patient, then try to generalize the conclusion. So I think it's irrelevant.
Q. (BY MR. THORNBURGH) Well, you've offered opinions that some of the risk factors that lead to mesh-related complications would be things like diabetes and smoking, right?
A. Yes. Based on literature, it says in that way, that's true.
Q. So my only question is, because Mrs. Corbet was not a smoker, that wasn't a risk factor for a mesh-related complication, right?
A. But if she has other risk factors, it's -- that's why it's individually based. It's not because she has -- she's not smoker, then she has no risk factor.
Q. We're going to talk about all those, but in your report, you'd indicated there were certain risk factors that individual patients had, and you indicated that smoking was a risk factor, diabetes was a risk factor, and obesity --
A. Correct.
Q. -- were risk factors for mesh-related

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complications, right?
A. Correct.
Q. And Mrs. Corbet was not a smoker, didn't have diabetes, and wasn't obese, correct?
MR. VOUDOURIS: Objection.
A. What else I mention in the risk factor category?
Q. (BY MR. THORNBURGH) Well, what are the other risk factors?
A. Right. So you -- I think you are intentionally ignore. And, also, I said lower estrogen level, okay? Lower estrogen level. Lower estrogen level actually is the main factor.
Q. So what's the basis for your opinion that because, number one, that Mrs. Corbet had a lower estrogen level?
A. She's a postmenopausal, right, 61 years old.
Q. So postmenopausal, 61 years old?
A. Right.
Q. Any other basis?
A. That's classical situation for a lower estrogen level.
Q. And so what -- are you referring -- is there some publication that says that if you have lower estrogen levels, you're at risk of suffering some

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mesh-related complication?
A. Because lower estrogen level -- women with lower estrogen level are postmenopausal situation. The vagina tend to become atrophic; therefore, atrophic one -- vaginas will have a thinner mucosa lining. And the thinner mucosa linings has a tendency to have injury or dyspareunia, or even if you have an implantation of the mesh, then it's -- it's being considered as a risk for mesh exposure.
Q. If you look at page -- the report that starts on page 23, is there any indication in this report at this time that Mrs. Corbet had vaginal atrophy?
A. It's not stated.
Q. Based on your review of the medical records, when was Mrs. Corbet first diagnosed or -- or observed to have vaginal atrophy?
A. Vaginal atrophy diagnosis usually is not being provided, okay, because this is a common situation in postmenopausal women.
Q. What level of vaginal atrophy places a patient with a mesh device at risk of developing a mesh-related complication?
MR. VOUDOURIS: Objection.
A. I'm not able to -- to provide accurate number of, you know, what the level -- what the percentage of

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the risk the lower estrogen may contribute, but overall, this is accepted concept in the field. Postmenopausal woman has a tendency to complain this, okay?
Q. (BY MR. THORNBURGH) And you -- do you understand from looking at the medical records that Mrs. Corbet was taking hormone replacement therapy?
A. I was not aware how long she was taking the hormone replacement, number one.
Number two, I also notice that there's a pathology report from -- I think from the report that we just discussed before lunch. In the microscopic discussion description, it says there is fibrosis in the vaginal mucosa they trimmed, okay? So that is the part of the evidence -- pathological evidence to support the -- the vagina has at least certain degree of atrophy.
Q. Fine. So it's your --
A. Fibrosis.
Q. It's your testimony that based on one of Mrs. Corbet's -- in fact, the explant pathology report from the procedure that removed the TVT, the finding of fibrosis in the vaginal mucosa was evidence of atrophy?
MR. VOUDOURIS: Objection to form.
A. No. No.
Q. (BY MR. THORNBURGH) I thought -- I'm just

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trying to understand.
A. Yeah.
Q. I thought your testimony was, the finding -- the pathological finding of fibrosis in the lining --
A. She has two specimens. Okay. One specimen is the -- trim the vaginal mucosa, which does not contain any mesh, okay? Because the surgeon, Dr. Harrell, was doing prolapse repair. I don't know if you are -- if you noticed that.
MR. VOUDOURIS: Page -51 of your exhibit, that's what he's referring to.
A. And then within that pathology report in the microscopic description after the diagnosis, it says vaginal mucosa shows fibrosis. This is different from the explanted mesh.
Q. (BY MR. THORNBURGH) Okay. So if we turn to page -51, and that's the pathology report that was done or performed after the implant procedure at -- on specimen removed during the implant procedure?
A. That's during the implantation.
Q. Okay. What's the lamina propria?
A. Lamina propria means underneath the squamous mucosa. That's the connective tissue layer.
Q. And where was this tissue removed from?
A. That's from the vagina.

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Q. What part of the vagina?
A. I think you -- if you want to know exact --
Q. Go to page -- go to page -49. We'll look at the implant operative report.
A. Yeah.
Q. Okay. You see that this is -- the date of the surgery was July 14th, 2011?
A. Right. The same date for the implantation.
Q. Okay. And the procedure was an anterior and posterior repair of -- colporrhaphy?
A. Right.
Q. And for the benefit of the jury and the court, what is a colporrhaphy?
A. It's a repair of the prolapse, basically.
Q. Using what?
A. Using -- I'm not -- because I'm not a surgeon, okay? I don't know what kind of material they use or they -- what kind of method to use. Mainly -- the main purpose for this kind of surgical procedure is to correct the prolapsed organ, therefore to improve the symptoms the patient experienced.
Q. Okay. And you see that the reason for the anterior repair was a grade 1 cystocele?
A. Yes.
Q. And the reason for the posterior repair was a

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grade 2 rectocele?
A. Right.
Q. Okay. And if you look at this -- and also during this procedure is when the TVT was implanted, right?
A. Yes.
Q. And do you have an understanding of where the TVT device would have been implanted in Ms. Corbet?
A. Just --
MR. VOUDOURIS: Objection.
Go ahead.
A. Just underneath the urethra area and within the vagina.
Q. (BY MR. THORNBURGH) A different location than where the grade 1 cystocele and grade 2 rectocele were identified?
A. That means one is anterior for -- for cystocele, that means the bladder prolapsed into the vagina or bulging into vagina. Then rectocele is the rectum bulging to the vagina.
Q. Well, you would agree that the surgery that occurred to repair the grade 1 cystocele would have been in a different -- different anatomical location than where the TVT mesh was implanted?
MR. VOUDOURIS: Objection; form.

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A. I disagree, because the overall, this is all vagina. It's considered an -- organ is -- within the vagina.
Q. (BY MR. THORNBURGH) Do you --
A. So therefore, it's the same location. But within the vagina, you have different location, that will be fine.
Q. Well, do you have an understanding that a rectocele or a cystocele can cause inflammation?
MR. VOUDOURIS: Objection; form, foundation.
A. Rectocele and cystocele depends on the degree. If they prolapse outside the vagina exposed to her pants, rubbing on her pant all the time, yes, inflammation will occur. That's very common.
Q. (BY MR. THORNBURGH) Okay. So you agree that a anterior -- or a rectocele can cause inflammation?
MR. VOUDOURIS: Object to form.
A. Anterior is cystocele. Posterior is rectocele, first of all.
Q. (BY MR. THORNBURGH) Right, right.
A. Yeah. If they have certain degree, reach to a certain degree of severeness, then inflammation may occur.
Q. What degree or grade of a rectocele can cause

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inflammation?
MR. VOUDOURIS: Objection; form and foundation, beyond the scope.
A. And, again, I -- I'm not a surgeon, number one. And I do not perform these surgeries. And what I -- my expertise is within the pathology field. So I think these questions are best answered by the surgeon.
Q. (BY MR. THORNBURGH) So is it fair to say that regarding the -- is it -- so is it fair to say that you can't reach an opinion to a reasonable degree of medical certainty or probability whether or not the cystocele or the rectocele caused inflammation which was identified and found on the pathology report from that -- from the implant procedure?
MR. VOUDOURIS: Object to form.
A. I think that's irrelevant question for that. Because what I mentioned from the pathology report, they trimmed redundant vaginal tissue submitted to the pathology, right? And then within these redundant vagina tissue, they have found -- they have found the fibrosis within the vaginal wall or lamina propria.
Therefore, from those descriptions, although I did not review the slides yet, we don't have a question, but I -- we do not have these slides. But based on that pathology report, I can say she has

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certain degree of vaginal atrophy. That's very reasonable.
Q. (BY MR. THORNBURGH) Let's look at the implant operative report. Do you see it says -- in this report, it says, "A linear incision was made at the apex into the cystocele with a knife and Metzenbaum scissors were used to develop the cystocele with blunt and sharp dissection" [as read].
Did I read that accurately?
A. Yeah.
Q. And then it goes on to say that a suture was placed around the cystocele. Do you see that?
A. Yes.
Q. "And then it was tied down and the cystocele reduced" [as read].
Did I read that correctly?
A. Yes.
Q. And then it says, "Excess vaginal mucosa was excised" [as read]?
A. Correct.
Q. All right. And is it your understanding based on reviewing this report and based on your knowledge, training, and experience, that the excess vaginal mucosa was removed at the location of where the cystocele was located?

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A. Correct. It's part of vagina.
Q. Okay. And you don't know one way or the other whether or not the cystocele can cause inflammation?
MR. VOUDOURIS: Objection; form and foundation.
A. That's what I already say. The cystocele, if -- to a certain degree if they're protruding out -- outside of the vagina, sure, more or less will be related to the inflammation. That's a common knowledge.
Q. (BY MR. THORNBURGH) Okay. And then if you go to the next sentence, it says that they basically reapproximated the -- the anterior compartment with a running suture, right?
MR. VOUDOURIS: Objection.
A. Yeah.
Q. (BY MR. THORNBURGH) And basically, that means just closing the location where there was an incision?
A. Correct.
Q. It says -- goes on to say, "Approximately two-centimeter distal urethra" [as read].
Do you see that?
A. Yes.
Q. What -- what that does mean, approximately two-centimeter distal urethra?
MR. VOUDOURIS: Objection; form.

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A. Urethra is the opening close to the clitoris area in the vagina.
Q. (BY MR. THORNBURGH) Okay. So that's going to be a different location than where the excess vaginal mucosa was excised, right?
A. That's correct.
Q. It says, "At the distal urethra location, there was an incision made and the suburethra" [as read] -- strike that.
It says that, "At the urethra meatus an incision was made suburethrally approximately two centimeters in length. Dissection was taken out laterally. Injection was placed in the retropubic space both transabdominally and transvaginally" [as read].
Do you see that?
A. Yes.
Q. And do you have an understanding that the retropubic space is the location where the TVT device would have been placed?
A. Yes. That's the right place.
Q. And it goes on and describes the rest of the TVT procedure, right?
A. Yeah.
MR. VOUDOURIS: Objection.
Q. (BY MR. THORNBURGH) Including, you know,

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following the manufacturer's guidelines, right --
A. Yes.
Q. -- to perform the procedure?
And then the similar procedure was performed on the other side --
A. Correct.
Q. -- right?
All right. And then it goes on to say, "There was no" -- I'm sorry. It goes on to say -- regarding the posterior repair, if you turn the page to -50.
Actually, before we get to the posterior repair, it says that when the procedure was finished, that Dr. Harrell made sure there was good placement of the tape, not too loose, not too tight. Are you going to offer any opinions regarding whether or not Dr. Harrell, based on your pathological findings, had implanted the TVT device with too much tension?
MR. VOUDOURIS: Objection.
A. I'm not in the position to provide such comments or opinion.
Q. (BY MR. THORNBURGH) And there's -- and would you agree with me there were no pathological specimens that you could look at that would indicate that Dr. Harrell put the TVT device in with too much tension?

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A. That's not related to the pathologist specimen.
Q. Okay. Then going down a couple lines, it talks about the repair of the rectocele. It says, "A rectocele was developed in the suture was placed around it" [as read].
Do you see that?
A. Yes.
Q. It goes on to say it was tied down and reduced, meaning they -- they repaired the rectocele --
A. Posterior part.
Q. -- posterior?
And it says, "Excess vaginal mucosa was excised and reapproximated with a running lock of three vicryl" [as read].
Do you see that?
A. Yes.
Q. Okay. Do you understand -- have an understanding that that procedure would have been in the posterior?
A. That's -- that's for the posterior repair.
Q. At the location of the cystocele -- I'm sorry, at the location of the rectocele?
A. At the location of the rectocele.
Q. Okay. And if we turn the page to the

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pathology report dated July 14th, 2011, it says under -- do you see the vaginal -- or final diagnosis, and it says, "Vaginal tissue with mild chronic inflammation of lamina propria" [as read]?
A. Yes.
Q. Okay. And it's your understanding that was the location of the -- of the tissue that was -- strike that.
The tissue that was sent for pathology was tissue that was removed at the site of the rectocele and cystocele repairs?
A. Correct.
Q. And then you had offered an opinion that because -- it says the lamina propria displays fibrosis and a mild chronic inflammatory infiltrate, that -- that you believe that's evidence of an atrophic vagina?
A. Fibrosis is not a normal finding for a normal vagina in reproductive age woman.
MR. THORNBURGH: That wasn't my question, so I move to strike.
A. That's why -- but I want you to understand, because you're not in this field, right? And in a reproductive age woman's vagina, they have a good elasticity, because normal level of estrogen will support the normal vaginal function.

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Then in the lower estrogen levels, then vagina becomes atrophic, it changes, even in the certain degree of estrogen replacement or hormone replacement. Then that will be depending on the time of replacement, the length of replacement, the dose of replacement.

So then if the atrophy already being induced, then it is difficult to completely recover or back to the normal situation. Just like in postmenopausal woman, you want to go back to 30 years old reproductive age, it's unlikely.

Q. (BY MR. THORNBURGH) So is it your opinion that based on this pathological finding, that Mrs. Corbet had some degree of vaginal atrophy?

A. Correct.

Q. Do you know what degree of vaginal atrophy is described here?

A. I can't give what the degree or how much degree of atrophy had. But the -- yes, based on this fibrosis finding, it should be -- if the finding is true, then vaginal atrophy is there.

Q. And are there medications that can be taken to treat vaginal atrophy?

MR. VOUDOURIS: Objection.

Q. (BY MR. THORNBURGH) Let me ask a question: Did Mrs. -- a different question, I'll withdraw the last

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one.

Did Mrs. Corbet -- was Mrs. -- strike that.

Was Mrs. Corbet prescribed medications to -- that typically treat vaginal atrophy?

MR. VOUDOURIS: Objection; form and foundation, beyond the scope.

A. It is beyond scope. Do you want me to answer my --

Q. (BY MR. THORNBURGH) Was -- was -- was Mrs. Way -- I'm sorry, strike that.

Was Mrs. Corbet prescribed medication that is used to treat low levels of estrogen for vaginal atrophy?

MR. VOUDOURIS: Same objection.

A. I'm not aware -- when I read the things, I do not pay attention if she has received hormone replacement, okay? That's number one.

But, in general, any postmenopausal woman, if already to certain years, then certain physiological changes cannot be completely restored if hormone replacement is provided, okay? But hormone replacement does improve the symptoms, okay? Or change -- make the patient feel better, that's true. That's why the clinical indication many postmenopausal, if they have

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atrophic-related changes, yes. If there's no other contraindication for hormone replacement, then hormone replacement will be offered.

MR. SNOWDEN: He needs to change the tape.

MR. THORNBURGH: Okay. Go ahead.

THE VIDEOGRAPHER: We're off record at 1:54 p.m., end of Tape 2.

(Break taken.)

THE VIDEOGRAPHER: We're back on record at 2:05 p.m., beginning Tape 3.

Q. (BY MR. THORNBURGH) Doctor, before we went off the record, I'd asked you a question about risk factors that Mrs. Way --

A. Corbet.

Q. -- had regarding -- sorry. Strike that.

Before we went off the record, before we took a break, I asked you what risk factors Ms. Corbet had that you thought could increase the risk of mesh-related complications. And we had gone through a list: She didn't have diabetes, she didn't have -- wasn't a smoker, she wasn't obese, right?

A. Correct.

Q. And then you identified vaginal atrophy as a risk factor that Mrs. Corbet had; is that correct?

A. Correct.

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MR. VOUDOURIS: Objection.

Q. (BY MR. THORNBURGH) And did you identify -- other than -- strike that.

Other than the vaginal atrophy, did you identify any other risk factor for a mesh-related complication?

MR. VOUDOURIS: Objection.

A. So far, based on the records, we do not see any other related risk factors.

Q. (BY MR. THORNBURGH) I'm going to try not to go through all these records to try and get us out of here as quick as possible, but if you'll turn with me to the same exhibit, I think it's Exhibit Number 7.

A. Yeah.

Q. Bates number ending in -13?

A. Page 13?

Q. Yeah. Okay. You see that this record is dated October 12th, 2011?

A. Yes.

Q. And here, it says that Ms. Corbet is a 50-year-old female and she presents for a postoperative evaluation, right?

MR. VOUDOURIS: Objection. 58?

MR. THORNBURGH: 58-year-old female is what it says.

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MR. VOUDOURIS: You said 50.
MR. THORNBURGH: Oh. 58-year-old female.
A. Correct.
Q. (BY MR. THORNBURGH) And the postop -- this postop visit was related to a follow-up for her anterior repair, her posterior repair, and the TVT, right?
A. Yes.
Q. You see here in this paragraph it says, "She has voiding and control better with sancturra and Valium and still has occasional spontaneous leak. Complain of pain with sex and urge to deficate with sex. Has had vaginal bleeding with sex. Less each time" [as read].
Do you see that?
A. Yes.
Q. So this is three months postop -- postimplant procedure, right?
A. Yes. From July to October.
Q. Okay. And she's reporting for the first time a complaint with pain during intercourse, right?
MR. VOUDOURIS: Objection.
A. Based on this report.
Q. (BY MR. THORNBURGH) And also bleeding with intercourse, right?
A. Right.
Q. Okay. And then also, it says that she --

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"There was a small -- small area of granulation tissue with vaginal -- vag mildly tender mass on one from abdominal wall to 5 o'clock and vag moblie" [as read].
Do you see that?
A. Yes.
Q. Okay. So what -- what is granulation -- what is granulation tissue?
A. Okay.
MR. VOUDOURIS: Objection.
A. Granulation tissue is the term -- as a pathology term -- describing the wound healing, okay? Any injury or surgical procedures is considered as an injury for tissue. Then during the healing process, if the healing process does not heal well, then you have granulation tissue. Okay. Granulation tissue is composed by fibroconnective tissue, vessels, and inflammation.
Q. (BY MR. THORNBURGH) And -- and do you also have an understanding based on your review of the records that you reviewed in this case that granulation tissue is also an indication of a tissue response to synthetic polypropylene mesh?
MR. VOUDOURIS: Objection; form foundation.
A. This one can be totally unrelated, because

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patient received three procedures, right, anterior repair, posterior repair, and TVT implantation. So this area of granulation tissue can either represent delayed healing process or recent injury by her -- any sexual activity or something like that. These -- all things can happen -- can cause this granulation tissue.
Q. (BY MR. THORNBURGH) Is it -- is it -- is one of the things that might -- is -- strike that.
Is it possible that for Mrs. Corbet one of the possible explanations for the granulation tissue that was identified on October 12th, 2011, is also the placement of the TVT device that she had implanted three months prior?
MR. VOUDOURIS: Objection; form, foundation.
A. I have no comment on that. I think the best person to answer this question will be the surgeon, Dr. Smith.
Q. (BY MR. THORNBURGH) Okay. So you're not going to offer an opinion one way or the other regarding the granulation tissue; is that fair?
A. That's why I say granulation tissue overall is related to the injury and delayed healing process. That's it.
Q. Other than that, you're not going to come in

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at trial and try to offer an opinion regarding what the cause of the granulation tissue was that was identified three months after the mesh implant?
A. No.
Q. Okay. No, you're not going to offer those opinions, right?
A. No.
Q. Is -- for Mr. Way, was placement of the mesh --
MR. VOUDOURIS: Objection.
MR. THORNBURGH: Sorry.
Q. (BY MR. THORNBURGH) For Mrs. Corbet -- sorry.
For Mrs. Corbet, was placement of mesh a -- also a risk factor for erosion?
MR. VOUDOURIS: Objection; form, foundation, beyond the scope.
A. Based on literature findings, mesh exposure or erosion is a lower complication rate. Overall, it's about maybe three percent or less, okay? So therefore, implantation of the mesh to correct stress urinary incontinence, basically is a -- has a lower rate for this kind of complication, that's the overall situation.
Q. Well, isn't it true, though, that if Mrs. Corbet did not have mesh implanted, she wouldn't have experienced a mesh erosion?

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MR. VOUDOURIS: Objection.
A. If no mesh -- no mesh exposure, that's for sure. However, if any woman -- postmenopausal woman, even without any implants or mesh or other things, then they still may experience ulceration or laceration or other things or injury.
MR. THORNBURGH: Motion to strike nonresponsive.
Q. (BY MR. THORNBURGH) My question simply was: If she didn't have mesh implanted, she wouldn't have had mesh erosion?
MR. VOUDOURIS: Objection; asked and answered.
Q. (BY MR. THORNBURGH) Right?
A. Yeah. Correct.
Q. Now, eventually, Mrs. Corbet went to see Dr. Smith, right?
A. Yes.
Q. And do you have a recollection of why Mrs. Corbet went to see Dr. Smith?
A. Based on Dr. Smith's deposition, she complained of dyspareunia, then she went to see her.
Q. In fact, if you -- if you look at Exhibit 7, there's a letter from Dr. Smith to Dr. Harrell concerning her evaluation of Ms. Corbet, right? Do you

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remember seeing that letter?
MR. VOUDOURIS: Page?
A. Can you tell me the page number, please?
Q. (BY MR. THORNBURGH) Page 26 -- no, it's not, sorry. Page 27.
I mean, maybe this saves us some time. Did you consider these records in reaching your opinion in your case?
MR. VOUDOURIS: Objection.
A. I -- I want to read and understand the clinical situation, that's true. But many pure clinical-related information, I may not be qualified to answer because I'm a pathologist.
Q. (BY MR. THORNBURGH) Okay. Because I don't want to -- you know, I don't want to go over things that you didn't rely on in reaching your opinions in this case. So to the extent that you didn't consider and rely on the medical records in this case, it may save us some time.
So did you consider these records in reaching your opinions or not?
MR. VOUDOURIS: Objection; asked and answered.
A. The medical records will be useful for me, but my opinion mainly rely on the histological findings I

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observed. So it's not like just a -- a yes-or-no answer.
Q. (BY MR. THORNBURGH) Was it -- was it significant to you that before Mrs. Corbet had the mesh implanted, she didn't have any complaints of dyspareunia or pelvic pain?
MR. VOUDOURIS: Objection; form, beyond the scope.
A. Yeah, that's a clinical complaining. Then also, she experience some kind of bleeding also.
Q. (BY MR. THORNBURGH) There's --
A. Right.
Q. Well, your --
A. So that's --
Q. -- related to her hysterectomy, but my question to you is: Was it significant in your mind or did you consider, in rendering your opinions, the fact that she did not have any symptoms or complaints regarding painful intercourse prior to having the mesh implanted?
MR. VOUDOURIS: Objection; form, foundation, beyond the scope, compound.
A. Again, this is a clinical symptoms. I do not rely on these clinical symptoms then, you know, use these clinical findings to interpret my pathological

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findings. That's for sure.
Q. (BY MR. THORNBURGH) So I'm just trying to determine whether or not I need to ask you any questions about the medical records. Let me -- let's talk about this one. So this record is dated January 31st, 2013, Bates number -27. Have you seen this record before?
A. Yes.
Q. Okay. And do you recognize this is a letter from her -- eventually her explanting physician, Dr. Smith, to the implanting physician, Dr. Harrell?
A. Yes.
Q. Do you see where it says that Ms. Corbet was evaluated for severe overactive bladder and recent bleeding episodes?
A. Yes; that's the chief complaint.
Q. Okay. Did you have an understanding that those conditions or symptoms occurred at some point after placement of the TVT device?
MR. VOUDOURIS: Objection.
A. From time -- time consideration, yes, her -- this finding is after TVT implantation.
Q. (BY MR. THORNBURGH) Okay. And do you see the chief complaint?
A. Yes.
Q. What is the chief complaint?

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A. That's the main complaint, the main feeling from the patient.
Q. And what does it indicate that her main problem -- Mrs. Corbet's main problems were on January 31st, 2013?
MR. VOUDOURIS: Objection; form.
A. As you mentioned, it's overactive bladder as well as dyspareunia.
Q. (BY MR. THORNBURGH) And so it says overactive bladder and pain in the vagina during intercourse, right?
A. [Nods head.]
Q. And do you see where it says that Mrs. Corbet presented for consultation regarding bladder spasms and hematuria?
A. Yes.
Q. Okay. And are you going to offer any opinions regarding -- regarding the cause of the bladder spasms?
MR. VOUDOURIS: Objection; beyond the scope.
A. No.
Q. (BY MR. THORNBURGH) Okay. And -- and are -- and hematuria is bleeding, right?
A. Hematuria is bleeding from the urine.
Q. From what, I'm sorry?

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A. Urine.
Q. Okay.
A. Urination.
Q. And are you going to offer any opinions concerning hematuria?
MR. VOUDOURIS: Objection; beyond the scope.
A. I can tell you based on the pathology report that she had benign papilloma, all right, and that benign papilloma is related to the hematuria. That's the only thing I can tell you.
Q. (BY MR. THORNBURGH) Do you see where -- so at least at this point in January 31st, she's complaining of severe overactive bladder disorder and bleeding episodes as well as pain in the vagina during intercourse, right?
A. Correct.
Q. And you had said that you had reviewed the Hill article in preparation for the deposition, right?
A. Yes.
Q. And the Hill article actually talks about voiding dysfunction and overactive bladder disorder associated with inflammatory response in women with mesh explants, right?
MR. VOUDOURIS: Objection.

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A. I'm not sure which sentence -- which paragraph you referring.
Q. (BY MR. THORNBURGH) I'll go ahead and mark as Exhibit Number 8.
A. 8.
(Exhibit Number 8 was marked.)
Q. I've handed you Exhibit Number 8, which we talked about earlier on today, which is the article called "Histopathology of Excised Midurethral Sling Mesh" by Hill and others.
MR. VOUDOURIS: Dan, I believe they made three copies.
MR. THORNBURGH: Sorry. That wasn't on purpose.
Q. (BY MR. THORNBURGH) It's -- are you familiar with this document?
A. I have read, but if you asking very specific questions, certainly, I have to read again.
Q. But this is the document that you're referring to earlier in today's deposition?
A. Yes.
Q. This is the new document that you provided -- or which was provided in Exhibit Number 2 as new literature that you've reviewed?
A. Correct.

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Q. And which you rely on for purposes of your opinions in this case?
A. I don't mean rely on opinion of this, because this is a histopathological finding of these explant sling, therefore, it's related to the pathology finding. That's the -- the purpose I read this article.
Q. So this is an article that was published after you had served your expert report, right?
A. Correct.
Q. And it says that, "The purpose or objective of the study was to compare the histological characteristics of pathological specimens excised mid -- midurethral sling mesh and surrounding vaginal tissue in patients who presented postoperatively with pain and/or" [as read] --
MR. VOUDOURIS: Objection. I think it says preoperative.
Q. (BY MR. THORNBURGH) "Present preoperative -- operatively with pain and/or exposure of mesh to patients who underwent mesh excision for voiding dysfunction without pain and erosion" [as read].
Did I read that correctly?
A. Correct.
Q. And this was a retrospective case control study, correct?

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A. Yes.
Q. Of 130 patients?
A. Yes.
Q. And do you see the -- do you recall that in the study, they divided out these patients or their subjects into three groups?
A. Yes.
Q. Women who had voiding dysfunction without pain, women who had pain and/or exposure, and then women who had voiding dysfunction with pain and/or mesh exposure?
A. It's a combination, yes.
Q. Did you rely on this in any way regarding your opinions concerning Mrs. Corbet's mesh explant or the complications from mesh?
A. I do not rely on what they have found to generate my opinion, because my opinion has been generated before this publication came out.
Q. Did you consider it, though, in offering your opinions?
MR. VOUDOURIS: Objection; form.
A. I don't think this is relevant, because I did not change my opinion at all since last year.
Q. (BY MR. THORNBURGH) Well, Mrs. Way -- Mrs. Corbet had TVT, midurethral sling implanted, right?

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A. Yes.
Q. She -- as we saw from the medical records, she had postimplant voiding dysfunction, right?
A. Yes.
Q. And she also had pain and exposure, right?
A. Yes.
Q. So how is that not relevant to your opinions in this case concerning Mrs. Corbet?
MR. VOUDOURIS: Objection; form.
A. Because my opinion has been basically formulated before this publication came out, number one.
Number two, the -- the findings really will not influence my judgment or my comments or my understanding for the -- for the mesh explants. So therefore, why I have to heavily rely on this finding. But yes, this is a good paper to describe histological findings on these meshes.
Q. (BY MR. THORNBURGH) Did you have any disagreements with the information in the Hill article?
A. I don't have disagreements --
MR. VOUDOURIS: Objection.
A. -- for that.
Q. (BY MR. THORNBURGH) Do you have a disagreement with the method they used in evaluating mesh explant pathologically?

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MR. VOUDOURIS: Objection.
A. No. They are reasonably, you know, planned -- planned for the study.
Q. (BY MR. THORNBURGH) And you see the result section --
A. Yes.
Q. -- in the abstract?
A. Correct.
Q. It says, "60, 42 percent, with voiding dysfunction only. 21 or 16.2 percent with pain/erosion. And 19, which is 37.7 percent, with both pain and exposure and voiding dysfunction were evaluated" [as read], right?
A. Correct.
MR. VOUDOURIS: Objection; form.
Q. (BY MR. THORNBURGH) It says, "The voiding dysfunction only group was found to have significantly higher levels of inflammation, median grade 2 on a scale of 1 to 3" [as read], right?
A. Yes.
Q. "Compared to the other two groups with a P value of .007. There were no statistical differences in fibrosis" [as read].
What's fibrosis?
A. Fibrosis means lots of collagens.

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Q. It's a scar, right?
MR. VOUDOURIS: Objection.
A. No.
Q. (BY MR. THORNBURGH) Scar tissue?
MR. VOUDOURIS: Objection.
A. No.
Q. (BY MR. THORNBURGH) You don't believe that fibrosis is scar?
MR. VOUDOURIS: Dan, this was covered --
MR. THORNBURGH: Okay.
MR. VOUDOURIS: -- extensively in his other deposition, pages.
Q. (BY MR. THORNBURGH) In any event, they're talking about their findings -- their findings within these two -- within these three groups regarding fibrosis was that there was no statistical significant -- statistical differences in fibrosis and giant cell reaction between the three groups?
A. Correct.
Q. In other words, in all three groups, they had the same level or severity of fibrosis and giant cell reaction, right?
MR. VOUDOURIS: Objection.
A. Based on this study, yes.
Q. (BY MR. THORNBURGH) Do you recall what their

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findings were with respect to the fibrosis and giant cell reaction in these three groups?
A. They have definition within the table. It says histological grading system, chronic inflammation, you have, basically -- I think all these things we have described.
Q. Well, actually, do you see where it says -- if you go to the table 1, which is the histological grading system --
A. Yeah.
Q. Did you use this same grading system in your analysis of Mrs. -- or similar grading system --
A. Yes.
Q. -- in your analysis of Mrs. Corbet?
A. As I mentioned that, I think, before this publication came out, in general, pathologists will use similar grading system.
Q. Okay. And so regarding fibrosis, they have basically four grades, right?
A. Yes, from 0 to 3.
Q. And they say 0 is no fibrosis?
A. Right.
Q. I guess that means no collagen?
MR. VOUDOURIS: Objection.
A. No --

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Q. (BY MR. THORNBURGH) No fibroconnective tissue?
A. Yeah, mainly fibroconnective tissue.
Q. Mild would be predominantly loose connective tissue with focal fibrosis?
A. Yes.
Q. And then moderate was focal dense fibrosis. And then marked as dense fibrosis with formation of fibrous nodule plaque?
A. Correct.
Q. And then for their inflammation, they, again, have a grading system based on no inflammatory cells, sparse chronic inflammatory infiltrate, confined areas of giant cell reaction, moderate is chronic inflammation infiltrate in areas of giant cell reaction involving adjacent connective tissue?
A. Correct.
Q. Okay. And marked would be the highest on the scale, which would be marked inflammatory infiltrate in areas of giant cell reaction and prominently involving connective tissue, any germinal center formation?
A. Correct.
Q. What's germinal -- germinal center formation?
A. It's a lymphoid aggregates, like within the lymphoid tissue, you have germinal center. It's a pure

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pathology term.
Q. Okay. If you go to -- see the results section on page 592 of Exhibit 8?
A. Yes.
Q. You see it says, "50 -- 45.4 percent of these patients underwent mesh excision for voiding dysfunction" [as read].
Did I read that accurately?
A. Yes.
Q. And then, "16.2 percent underwent excision for both pain and exposure and voiding dysfunction. And the remaining 49, or 37.7 percent, underwent surgical excision for both pain, exposure, and voiding dysfunction" [as read].
A. Correct.
Q. Almost 40 percent underwent surgical excision for pain, exposure, and voiding dysfunction?
A. Correct.
Q. And would that be the group that Mrs. Corbet would have been in if she was involved in this study?
MR. VOUDOURIS: Objection; form.
Q. (BY MR. THORNBURGH) In other words, is that -- is that -- is that the -- I'll withdraw that question.
A. Okay.

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Q. If you go to the next page --
A. Yes.
Q. -- most common finding in all groups is mild inflammation, 53 percent?
A. Yes.
Q. Then it says, "Only 9.2 percent of specimens showed no inflammation" [as read].
So very little of the explant showed no inflammation, right?
MR. VOUDOURIS: Objection.
A. 10 -- about 10 percent, yeah.
Q. (BY MR. THORNBURGH) Moderate or marked inflammation was noted in 48 or 39 -- 36.9 percent of the specimens, right?
A. Correct.
Q. And then the specimens in the voiding dysfunction only group found to have higher amounts of moderate inflammation.
And then it talks about the fibrosis. It says in the next paragraph, it says, "Moderate fibrosis was seen in 61 percent of pathological specimens with no difference found between the three groups" [as read]?
A. Correct.
Q. Did I read that correctly?
A. Yes.

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Q. And so they're saying that in the cohort that they looked at of 160 something patients --
A. 130.
Q. 170?
A. -30.
Q. 130. In that cohort, 61 percent, greater than half of those patients, specimens demonstrated moderate fibrosis in all groups?
A. Correct.
Q. And that almost all of the specimens that they looked at demonstrated giant cell reaction?
MR. VOUDOURIS: Objection to form.
A. That's a common finding.
Q. (BY MR. THORNBURGH) It's a common finding to observe --
A. From explanted mesh specimen.
Q. Do you see the discussion section, it says, "The optimal implant into human tissue has been described as one that does not illicit a significant post-tissue reaction, is lightweight, maintains flexibility, and provides long-term support" [as read]?
MR. VOUDOURIS: Is there a question?
Q. (BY MR. THORNBURGH) Do you see -- do you see that section?
A. I see the sentence, yes.

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Q. Okay. And --
MR. VOUDOURIS: Dan, you know --
MR. THORNBURGH: This is a new -- this is a new publication.
MR. VOUDOURIS: No, I'm not -- I'm not disputing that, but, you know, you're talking about trying to save time. You're reading sentences from medical records and from a literature and asking him if that's what -- did I read that correctly.
MR. THORNBURGH: No. And I'm going to follow up with a question. I didn't say -- I said do you see that section. The next question is --
MR. VOUDOURIS: I'm just -- I'm just pointing out what you've been doing for the last 30 minutes, which is in contradiction to trying to get through this as quickly as possible.
Q. (BY MR. THORNBURGH) Doctor, do you have any disagreements with the -- with these authors who write that the optimal implant is one that is lightweight?
MR. VOUDOURIS: Objection; beyond the scope.
A. Yeah, this one, lightweight, heavyweight, these mainly belong to material experts. I --
Q. (BY MR. THORNBURGH) So you're not going to offer an opinion one way or the other?

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A. I'm not going to render my opinion regarding these material weight issues.
Q. So this study found that 60 percent of all the explants had moderate fibrosis?
A. Yes.
Q. Which is fibroconnective issue?
MR. VOUDOURIS: Objection.
A. Which, yes, within the fibroconnective tissue.
Q. (BY MR. THORNBURGH) And if you look over to the next page, 594, there are some figures where they describe the different grades by showing microphotographs of explant specimens, right?
A. Correct.
Q. Okay. And do you have any disagreement with the depiction in their microphotographs of the way they graded the -- their explant specimens?
A. No.
MR. VOUDOURIS: Objection; broad.
A. I -- I agree, because I use similar grading system and also use similar representative pictures.
Q. (BY MR. THORNBURGH) In your experience -- strike that.
Based on this grading system -- strike that. I'm going to -- I'm going to try to skip through it.

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Do you see additionally on the right -- on the right side of page 594 --
A. Second paragraph?
Q. Yeah. It says, "Presence" -- it says, "One could have" -- sorry. "Additionally, our findings could be a result of tissue remodeling fibrosis that may occur following placement of midurethral slings. One could hypothesize that in the presence of inflammatory state, the sling may retract and shrink, therefore applying undue tension along its path, which, in turn, may lead to increased levels of voiding dysfunction" [as read].
A. That's their discussion.
Q. Okay. So they're --
MR. VOUDOURIS: Hold on. Wait for the question.
Q. (BY MR. THORNBURGH) Is it fair to say that what they're saying here is that as a result of the inflammatory response, voiding dysfunction could be a symptom of mesh contraction or shrinkage?
MR. VOUDOURIS: Objection; form, foundation.
A. That's their opinion and discussion for the point, but it's not my opinion.
Q. (BY MR. THORNBURGH) You have -- do you have an opinion about this statement that you're going to

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offer at trial?
MR. VOUDOURIS: Objection. All of these areas were covered extensively in his other deposition.
Q. (BY MR. THORNBURGH) At least these authors are indicating that voiding dysfunction in women implanted -- implanted with midurethral slings could be a symptom of the inflammatory response causing retraction or shrinkage of the scar tissue around the mesh, right?
MR. VOUDOURIS: Objection; form, foundation --
A. I -- I don't have --
MR. VOUDOURIS: -- speculation.
A. -- any evidence from -- based on the histological findings from many explanted sling I observed. I don't have evidence to support --
Q. (BY MR. THORNBURGH) I think they're --
A. -- that statement.
Q. I think what they're suggesting is that the evidence would be based on a clinical symptom of voiding dysfunction, right?
MR. VOUDOURIS: Objection --
A. Therefore --
MR. VOUDOURIS: -- hypothesis, form, foundation.

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A. Therefore, we are talking two different things. And my opinion mainly based on the pathological findings.
Q. (BY MR. THORNBURGH) Is it your -- are you saying that another expert like a urogynecologist should be the -- would be the appropriate person to ask concerning whether or not -- or to offer an opinion concerning whether or not voiding dysfunction is a symptom of mesh shrinkage?
MR. VOUDOURIS: Objection.
A. That's your choice.
Q. (BY MR. THORNBURGH) Because it's a clinical finding?
A. Yeah.
Q. And you're not offering opinions on clinical findings?
A. Correct. Because I'm not -- I don't have expertise like that.
Q. You also had indicated earlier in the deposition that you were providing the Smith article as a new article to your reliance list, right?
A. Correct.
(Exhibit Number 9 was marked.)
Q. I'm just going to mark this exhibit.
MR. VOUDOURIS: Dan, I believe that was

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already --
MR. THORNBURGH: Smith?
MR. VOUDOURIS: It's an exhibit to his deposition in Edwards.
MR. THORNBURGH: Oh. He testified -- he testified earlier that it was a new article that he was providing on Exhibit 2. That's what he testified to. The date of this article is --
MR. VOUDOURIS: Hold on.
MR. THORNBURGH: -- 2013. I wasn't going to ask -- all I'm doing is marking it for the purpose of the record since he -- since he testified about it earlier.
MR. VOUDOURIS: That's fine. If you're just going to mark it for purposes of the record --
MR. THORNBURGH: Yeah.
MR. VOUDOURIS: -- that's fine.
THE WITNESS: Right. That's fine.
MR. THORNBURGH: Do you want a copy of it?
MR. VOUDOURIS: Sure. And this is going to be 10.
MR. MORRIS: 9.
MR. THORNBURGH: 9.
MR. VOUDOURIS: Hill was 8?
THE REPORTER: Yes.

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Q. (BY MR. THORNBURGH) Was that the article that you were referencing earlier?
A. Correct.
Q. And you've already provided testimony in another case concerning that -- that article?
A. No. At that time, when I wrote my expert report, I was not aware of this publication.
Q. Okay. So is there something in that publication that you felt was relevant to your opinions in Ms. Corbet's case?
A. No.
(Sotto voce conversation.)
Q. I think that your -- I think your testimony is that this is something that you didn't consider when you authored your report in Mrs. Corbet's case?
MR. VOUDOURIS: Objection.
A. I do not cite this paper for my report. And I mentioned this publication mainly because I concurred with their findings recently, because many specimens pathology department received, actually, they do not have microscopic finding. That's the main point I presented earlier, okay?
MR. VOUDOURIS: Doctor, it's okay but when you gave your deposition in April of 2014, this Exhibit 9 was marked as Exhibit 3 in that deposition,

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and you were asked questions about it. So that --
THE WITNESS: Oh, I may forgot.
MR. VOUDOURIS: That -- to use a term we used earlier, that's a field that's already been plowed.
THE WITNESS: Okay. Sorry for this. I was confused, maybe.
Q. (BY MR. THORNBURGH) And I'm not going to ask you any questions.
A. Okay.
Q. I just want to mark it for the record.
A. Okay.
Q. Okay. Let's -- let's turn to your -- your expert report.
A. Sure.
Q. And I believe most of your report, your general report has already been -- you've already been questioned about it at prior depositions, right?
A. Yes.
Q. So I'm going to turn your attention to page 9, which is section 2 of your report. It says, "Opinion specific to plaintiff Kathryn Corbet" [as read].
A. Okay.
Q. And so the -- you have a section here under the subsection (a) called patient history.
A. Yes.

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Q. And we've gone through some of that history briefly, but was any of this --
MR. VOUDOURIS: Objection.
Q. (BY MR. THORNBURGH) Was any -- any of these findings, the history findings, relevant to your final conclusions or opinions in this case?
A. Yes.
Q. Okay. What findings in the patient history section of your expert report were significant to your opinions that you're offering in this case, clinical findings?
A. I think for the clinical findings when I write a report, I have to understand the whole situation, right, and what's the history and how those things happens. Then that's the -- that's the normal procedure.
It's not necessarily saying when I write down those patient history, then all these points I have to be used for -- to generate my opinion. Okay. That's the overall situation. So you're asking me which part or which sentence I have used significantly for my opinion, I think I am not able to answer this particular question.
Q. Was the explant report significant to your opinion in this case?

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A. Yes. And the pathology finding is the -- is the main finding, then my opinion will generate -- basically generated based on the pathological observation and examination.
Q. I'm just going to mark this exhibit and we're going to look at the explant report really quick.
(Exhibit Number 10 was marked.)
Q. I marked as Exhibit Number 10 the explant report of -- I'm sorry. I marked as Exhibit Number 10 the medical records from PennUrology for Mrs. Corbet.
And we already looked at the January 2013 record from -- from Dr. Smith to Dr. Harrell.
A. Yes.
Q. So why don't we just go ahead and look at the operative report regarding the explant procedure. It's on page 2 of Exhibit 10.
A. That's from Dr. Smith, right?
Q. Yeah. Do you see it?
A. Yes.
Q. Do you see where it says, "Preoperative diagnosis, eroded mesh, overactive bladder, and macroscopic hematuria" [as read]?
A. Yes.
Q. And so that -- it says that the procedure that was done was a cystoscopy, bladder biopsy, fulguration,

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excision of eroded -- the vagina mesh and urethrolysis, right?
A. Yes.
Q. And it says that, "Mrs. Corbet, a 59-year-old female, with a history of TVT sling and a cystocele repair, presented vaginal pain and was found on examination -- physical examination to have eroded vaginal mesh in the left lateral fornix of the vagina" [as read], right?
A. Yes.
Q. And she also had overactive bladder symptoms and microscopic hematuria, and therefore a cystoscopy was planned, right?
A. Yes.
Q. And so this is the procedure where the mesh was removed as well as a -- some other pathological tissue, a bladder biopsy, and sent to --
A. Pathology.
Q. -- pathology, right?
A. Correct.
Q. It says -- if you look at -- on page Bates number ending in -3, halfway down, it says, "Vaginal exposure was then allowed to be visualized of the left arm of the sling coming through the vaginal wall" [as read], right?

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A. Yes.
Q. An excision was made above and below the sling?
A. Yes.
Q. And -- and --
MR. VOUDOURIS: Again, Counselor, we're just going through records and repeating what's already been dictated.
MR. THORNBURGH: I -- I get it. I get it.
MR. VOUDOURIS: You're asking him what he's saying.
Q. (BY MR. THORNBURGH) What -- and do you -- do you understand that she went above and below the sling to make sure that she captured all of the mesh so that -- all -- enough tissue and mesh to be sent to pathology?
MR. VOUDOURIS: Objection; form.
A. She -- I think based on this sentence, her surgical procedure notes, she covers -- or removes the exposed area and a portion of the mesh in the left side.
Q. (BY MR. THORNBURGH) And there was only left -- only the left side up to the midline --
A. Correct.
Q. -- was removed, right?
A. Correct.

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Q. And so is it fair to say that Ms. Corbet continues to have mesh in her body?
A. Yes.
Q. And you're not going to offer any opinions about the mesh that remains in her body, correct?
MR. VOUDOURIS: Objection; beyond the scope.
A. Correct.
Q. (BY MR. THORNBURGH) And, ultimately, this is the mesh that you -- the pathology material that you analyzed?
A. I have received the slides from this specimen.
Q. And you only analyzed the slides related to the mesh and the mesh -- and the tissue attached to the mesh, right?
MR. VOUDOURIS: Objection; form.
A. And also, I -- I reviewed bladder biopsy too.
Q. (BY MR. THORNBURGH) I didn't -- I didn't see that in your report.
A. Oh, it's there.
Q. Okay. Maybe I missed it. So let's look at your report.
MR. VOUDOURIS: It's under gross findings.
MR. THORNBURGH: Off the record one second.

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MR. VOUDOURIS: Sure.
THE VIDEOGRAPHER: Off the record.
(Break taken.)
THE VIDEOGRAPHER: We're back on record at 2:54 p.m.
Q. (BY MR. THORNBURGH) Okay. So you're looking at your expert report, which is marked as Exhibit Number 2, and you had indicated that in response to my question whether or not you considered or reviewed the pathological findings of the nonmesh-related tissue that was explanted, and you said, yes, it's in my report. Can you point me out -- point to in your report and tell me where that's located?
A. Okay. So basically, that's in the gross finding. I said --
Q. What page are you on?
A. That's on Page 10, gross finding. All right. First -- second line, first batch includes three H&E slides, all right, labeled SB13-1565, A1, B1, and C1. And then later on, I say slide C1 represent excised mesh, while A1 and B1 were from bladder biopsies.
Q. Okay. So --
A. And then because bladder biopsy is not really related to the explanted mesh, therefore, I do not provide microscopic finding for these A1 and B1 slide,

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but I did review the slides. That's why I clearly remember there is a papilloma issue there.
Q. Okay. So is it your testimony that you actually looked at those pathological slides under a microscope but didn't take photomicrographs and put them in your report?
A. Correct --
Q. Were they produced --
A. -- because it's irrelevant.
Q. Were they produced as part of Exhibit Number 2?
A. The pictures in Exhibit Number 2 does not include pictures from A1 and B1, bladder biopsies, because I did not take any.
Q. Where are those microphotographs located?
MR. VOUDOURIS: Objection.
A. That's in the thumb drive, right?
Q. (BY MR. THORNBURGH) Oh, okay. I'm sorry.
MR. VOUDOURIS: I'm confused.
Q. (BY MR. THORNBURGH) I thought you said --
MR. VOUDOURIS: He -- he just said he didn't take photographs of --
MR. THORNBURGH: I thought he said he did take photographs of the bladder biopsy.
MR. VOUDOURIS: No.

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A. No.
Q. (BY MR. THORNBURGH) All right. You looked at them but didn't take photographs?
A. Right.
MR. VOUDOURIS: Correct.
Q. (BY MR. THORNBURGH) Gotcha.
And you did that because you didn't think that a bladder -- the condition that she had was related to -- in the bladder -- was related to the mesh?
A. Correct.
Q. When you looked at that -- that specimen under the slide or those specimens regarding the bladder biopsy under the microscope, did you look at those in regular -- how did you look at those? Was it polarized light microscopy or optical microscopy?
A. No. Just regular routine microscope, light microscope.
Q. I think you testified or you indicated in your expert report that you can see polypropylene when you -- when you look at the specimen using light microscopy or polarized light microscopy; is that right?
A. In both conditions, we can see if the plastic piece of filament is obvious, still remaining in the tissue, yes. Use routine microscope also can see that. But for small particles, typical it is not clearly

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visible until we use polarized lens.
Q. Okay. And you didn't look at the biopsy slides using polarized lens?
A. No.
Q. So if there was a small particle that migrated into the bladder causing a calculi, that is something that you would not have seen using regular light -- regular microscopy, right?
A. I did --
MR. VOUDOURIS: Objection.
A. I did not use polarized lens to examine the bladder biopsy because I feel there is no reason to do that.
Q. (BY MR. THORNBURGH) Have you ever seen any documents or internal documents that discuss particles migrating into the bladder --
MR. VOUDOURIS: Objection.
A. There --
Q. (BY MR. THORNBURGH) -- causing a calculi?
MR. VOUDOURIS: Objection.
A. There are reports some mesh erosions can be erode into bladder, that's true. But this is not for Ms. Corbet case.
Q. (BY MR. THORNBURGH) And so is the bladder biopsies that were performed -- or the bladder findings

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that were discussed in the pathology from the explant relevant at all for your opinions in this case?
A. Yeah. The reason Dr. Smith did a biopsy because she had -- patient had a hematuria, right? Then she did a cystoscopy and found a papillary lesion there. That's the reason she did a biopsy. And then her symptom of hematuria can be perfectly explained by the pathological finding.
Q. Okay. And then -- so if we go to -- back to page -- your case specific opinions section on Page 20 --
A. Yes.
Q. -- you start off basically by criticizing Dr. Iakovlev, right?
MR. VOUDOURIS: Objection.
Go ahead.
A. It's not really criticize, I think, because Dr. Iakovlev provide his opinion, and then when I read through, I feel many of the -- his opinion is incorrect. Therefore, I think these are more meaningful or relevant to provide the reason why this is incorrect and what is my opinion or my reason to -- to say -- you know, to provide such a -- such a report, basically.
Q. (BY MR. THORNBURGH) You say that he tries -- that Dr. Iakovlev tries to use CK -- Figure CK5

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and CK6 to generalize that the pain complained by Ms. Corbet is caused by these histological findings. And then you go into the next section of your report sort of rebutting Dr. Iakovlev's opinions, right?
A. Yes.
Q. Okay. And did you disagree with the findings observed by Dr. Iakovlev in CK -- Figure CK5 or CK6?
A. Can we --
MR. VOUDOURIS: Objection; broad.
Q. (BY MR. THORNBURGH) Well, you talk about how -- you say in this paragraph that the nerve fibers -- that -- you say here that Dr. Iakovlev described the nerve fibers shown by regular light microscopy and S -- S100 staining by assuming these nerve fibers represent a single -- or several nerve branches growing into the mesh pores.
So do you disagree with that finding, or that observation, from Dr. Iakovlev concerning Figures CK5 and CK6?
A. Then he further states that he -- the spaces within the mesh filled with dense collagen scar, which anchors and entraps the nerve in their positions. All right. Yes, I disagree that.
MR. VOUDOURIS: Doctor, you have Dr. Iakovlev's report --

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THE WITNESS: Right.
MR. VOUDOURIS: -- in front of you --
THE WITNESS: Right.
MR. VOUDOURIS: -- which has the photographs --
Q. (BY MR. THORNBURGH) I think we marked it --
MR. VOUDOURIS: -- CK5 and CK6.
Q. (BY MR. THORNBURGH) I think we marked it as Exhibit --
A. 5.
Q. -- 5.
A. Yeah. CK5 and 6.
(Sotto voce conversation.)
MR. VOUDOURIS: I believe they start on Page 108 of his report. But there's no question pending.
THE WITNESS: Yes; those are the questions -- those are the figures, correct.
Q. (BY MR. THORNBURGH) What page are you on, Doctor?
A. That's on the Page 108 of his report.
Q. Okay. So on Page 108 of his report is Figure CK5a, right?
A. Right.
Q. And Dr. Iakovlev writes under the figures that

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most nerves can be seen by any stain.
Do you agree with that?
A. Yeah. Most nerves are visible without staining. You can see that.
Q. And then he goes on to say that, "This nerve is present within a space between filaments, or a compartment within the mesh structure, which was filled by fibrous tissue during healing" [as read].
Do you see that?
A. Yes --
Q. Do you agree with --
A. -- I see that.
Q. I'm sorry. I thought you were done.
Do you see that?
A. Right.
Q. Do you disagree with that statement?
MR. VOUDOURIS: Objection; form.
A. I disagree because he said fibrous tissue. Actually, this is integrated tissue based on my opinion, number one. Number two, yes, the nerve found are located between two mesh fiber spaces.
First of all -- I have two points.
First of all, it's not necessary to say this location equals to -- to the location within the mesh pore because this is a two-dimensional structure, a

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two-dimensional picture. Within the mesh pore, you need a three-dimensional picture to show it's inside of the pore or just adjacent to the mesh. You understand what I'm referring?
Q. (BY MR. THORNBURGH) So I think I understand. I think when you -- when you actually look down at the slide --
A. Right.
Q. -- is it three-dimensional?
A. It's -- this is two-dimensional.
Q. Well, that's the -- that's the photograph.
A. Right. It's always two-dimensional.
Q. Even when you're looking at the slide like this?
A. Correct.
Q. Okay. So your opinion is that because it's two-dimensional, you can't tell whether or not it's within the mesh compartments?
A. Within the pore or outside of pore or just adjacent to the mesh.
Q. Okay.
A. Right.
Q. And so is --
A. It would be --
Q. Is that your criticism regarding --

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A. This is my -- my opinion. It's not a criticism, okay. It's a statement.
Okay. Number two is, these are peripheral nerve. Peripheral nerve is able to grow. All right? Dr. Iakovlev also made a similar statement. This is correct. Okay. Then if these tissue can grow just like tissue integration, so you're finding the nerve endings or nerve fibers adjacent to the mesh fiber or even within the mesh pore is a normal finding because this is a part of the tissue integration.
Q. Okay. So let me try to break that down.
MR. THORNBURGH: He's saying pore --
MR. VOUDOURIS: P-O-R-E.
MR. THORNBURGH: -- P-O-R-E.
THE REPORTER: Thank you.
THE WITNESS: I'm sorry.
Q. (BY MR. THORNBURGH) Okay. So, first, your first disagreement with his conclusion is that this isn't fibrous tissue; it's integrated tissue?
A. It's integrated tissue. It's a healthy tissue. It's not the fibrous or scar tissue.
Q. All right. So what's the basis for your opinion that the tissue, that we -- that the pathology slide that we're looking at in CK5a on 108 is integrated tissue and not fibrous tissue?

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A. Because you have vessel, you have healthy fibroblasts. You see the vessels there? And although he did not label that, but in other pictures, you -- you will see vessels.
Q. Where do you see vessels at?
A. Vessels are everywhere. Many, one, two, three, four and small -- these areas. Okay. All these little bit of space with linings, they are all vessels. These microvessels everywhere, okay, number one.
Number two, you see nerve, as he labeled it very clearly. In this field, you have several nerve fibers clearly seen there. Okay. And the nerve grow do not grow into pure scar. Nerve grow, you need a vascular supply or nutrition to keep alive. Okay. So these are -- that's the reason these are fibroconnective tissue. It's integrated tissue.
Q. Okay. So number one, you're saying that because nerves grow and are growing into the scar --
A. I didn't say --
MR. VOUDOURIS: Objection.
A. -- grow into the scar. That -- you are saying --
Q. (BY MR. THORNBURGH) Growing into the fibroconnective tissue?
MR. VOUDOURIS: Objection.

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A. Yeah. Together with the fibroconnective tissue, nerve can grow as part of the integrated tissue.
Q. (BY MR. THORNBURGH) Okay. So that's assuming that these nerves actually grew and didn't get entrapped, right?
MR. VOUDOURIS: I'll object; form, foundation.
A. That's why we're saying -- peripheral nerve can grow is a demonstrated fact. Everybody knows, okay? That's well-known medical knowledge, all right? So they can grow. Because after injury -- injury mean with -- the surgery itself is an injury, right? You've cut the tissue, you implant the mesh, that's injury. Then you create a space, mesh has a space.
And then these tissues will fill the space, become integrated tissue, and become mesh and tissue complex, which is a normal function for -- or the biological basis for the mesh to support or to correct the symptoms in a clinical side.
Q. (BY MR. THORNBURGH) So you -- let me ask this question: Do you at least agree that there's fibroconnective tissue bridging from pore to pore?
A. No. I didn't say bridging because bridging fibrosis is his term, all right? That's Dr. Iakovlev's term, bridging fibrosis, basically from one side to the other side of the mesh pore.

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Q. Do you think Dr. Iakovlev made that term up?
A. I -- I don't see anyone else use this term so far based on my understanding.
Q. You haven't seen Ethicon's internal documents dating back as far as 1990s discussing bridging fibrosis?
MR. VOUDOURIS: Objection; form.
A. Okay. Then --
Q. (BY MR. THORNBURGH) Is that correct, you haven't seen those documents?
A. I did not remember, you know, these terms came from those. But anyway --
MR. VOUDOURIS: Hold on, there's not a question pending.
THE WITNESS: Okay.
Q. (BY MR. THORNBURGH) So the one -- so we talked about you don't believe bridging fibrosis. That's a term that was made up.
MR. VOUDOURIS: Objection.
Q. (BY MR. THORNBURGH) And the next is -- well, let me ask you this -- let me withdraw.
You see the inflammation there, identified?
A. Yes. We have inflammation, yes.

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Q. Okay. What level of inflammation do you see in this slide?
A. It's where -- it's focal area -- first of all, this is only focal area --
Q. Uh-huh.
A. -- of the microscopic picture. This amount of inflammation most likely will be rendered as mild inflammation.
Q. And that's because -- I think, if I understand --
A. Because --
MR. VOUDOURIS: Hold on. Don't talk over each other, Doctor. Let him get his question out.
Q. (BY MR. THORNBURGH) If I understand the way that you look at these and the way you define, you know, put these into categories, you would call this sparse, scattered inflammatory infiltrates --
A. Yes.
Q. -- is that right?
And when you say "focal area," are you talking about a zoomed-in area? Is that what you mean by that or --
A. That's the area in this picture he use arrow with inflammation. See that?
Q. Alloy?

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MR. VOUDOURIS: Arrow.
A. Arrow.
Q. (BY MR. THORNBURGH) Arrow. Okay.
So the arrow -- so he's pointing to an arrow that shows inflammation, but you don't believe -- you believe that the location of that -- strike that.
You believe that the level of inflammation at the location of that arrow is mild?
A. I -- I say overall with this area you see adjacent, except this area, the remaining area has basically no inflammation.
Q. Okay.
A. Therefore, overall, this is mild inflammation.
Q. Okay. So let's -- let's try to figure this out. Can you take this pen. So if we -- when you talk about looking at the entire area and grading it based on the entire area, that would include the area adjacent and outside or away from the fibers, right?
A. Yes. I will estimate immediate close to the mesh fiber spaces, as well as a few millimeter away from the mesh fiber spaces or adjacent to fibroconnective tissue.
Q. Well, what's the level of inflammation around the mesh fibers at the location of the arrow?

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A. This area [indicating].
Q. So what's -- what's the grading that you would give that area for -- of inflammation?
A. If -- if this area alone almost everywhere like this, then this will be moderate.
Q. Okay. So circle the area that you see as moderate.
A. [Witness complies.]
Q. Okay. Can you just write -- draw an arrow to the circle that you made and write "moderate" for me so that we can see that on the exhibit.
A. [Witness complies.]
Remember, if I say similar area have to be found in the different places rather than just only one single focus --
Q. I hear you. Let's -- let's --
A. -- okay? So if you have more area like this, then I'm going to render as a moderate.
Q. So just --
A. If this is alone, this will be mild. Therefore, if you want me to say this picture alone represent what, this going to be mild.
Q. Well, no. Hold on.
A. Right?
Q. You just indicated earlier that it was

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moderate. When I asked you --
A. No.
Q. -- to write "moderate" --
A. No. When I say moderate -- if I say -- if I see many areas like this, all right, in the same specimens, then I will say this is moderate.
Q. But you testified a moment ago -- you circled the page, and you said, "If we look at this area alone where the circle is around the fiber, that would be moderate."
A. No. I said if I see this alone together with other areas like this, then will be moderate.
Q. If we look at -- if we look at the -- just the area --
A. Right.
Q. -- around the fiber, you agree with me that that's moderate inflammation, right, around the fiber?
MR. VOUDOURIS: Objection; form.
A. You are separating the whole situation, pointing to a very -- just like we -- we are talking about a forest, and you're pointing to a single leaf and what this leaf represents. That question becomes very difficult to answer.
Mild, moderate, and severe just follow, you can see. We discussed that already. I follow

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Dr. Hill's paper. It's very clear there. And also, we have other examples for mild and moderate area in my report too.
Q. (BY MR. THORNBURGH) Okay.
A. So that's the reason it's difficult to -- for you -- you want me circle this area, say it's mild, moderate, or severe.
Q. The area that you circled, if -- if the entire area, the entire slide, looked like the area that you circled next to the mesh fibers, that would be graded by you as moderate, right?
A. Yeah, I can say that.
Q. Because -- because there are a -- if we look at the definition from -- from Dr. Hall -- or Hill, from Exhibit 8, there's moderate chronic inflammatory infiltrates in areas of giant cell reaction around -- around the mesh fibers on that image?
MR. VOUDOURIS: Objection.
A. That's right. But still, you need amount. It's not like without amount you can just say in that way. I even cannot tell here there is giant cell or not because this micrograph is -- does not illustrate giant cell there.
Q. (BY MR. THORNBURGH) All right. So if we look at -- okay. And so you don't believe that this is

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fibroconnective tissue that -- in between the pores?
A. I believe these are fibroconnective tissue.
Q. Okay.
A. These are not scar tissue.
Q. What -- is fibroconnective tissue scar also -- is -- fibrosis is scaring, right?
MR. VOUDOURIS: Objection.
MR. THORNBURGH: I'm just trying --
MR. VOUDOURIS: Dan --
MR. THORNBURGH: I'm trying to understand his definition.
MR. VOUDOURIS: Yeah. No. I appreciate that. He gave his definition ad nauseam in the deposition --
MR. THORNBURGH: Okay. I'm not going to --
MR. VOUDOURIS: -- he gave in April.
MR. THORNBURGH: -- ask him to do it again. All right.
MR. SNOWDEN: He just gave it about five minutes ago.
Q. (BY MR. THORNBURGH) All right. So where do you see on exhibit -- on Figure K -- CK5a what you described as vessels?
A. Do you want me to label that?

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Q. Yeah; go ahead and label where you see it.
A. [Witness complies.]
I put a V, okay, there.
In this lower power, you easily can identify many vessels, V. If I magnify it to the higher power, we can see much better vessels. It's difficult for you to understand probably for micro -- microscopic picture.
Q. What's a vessel look like microscopically? Because it all looks the same to me.
A. Yeah. You should come to medical school. Okay.
Q. Do you see any vessels between this fiber and this fiber or that fiber [indicating]?
MR. VOUDOURIS: Objection.
Q. (BY MR. THORNBURGH) For the -- for the record, I'll just go ahead and mark 1, 2, and 3. So 1 -- 1, 2, 3. I've marked on Page 108 the fibers and asked if you see any vessels within or between fiber 1, 2, and 3.
(Witness reviewed document.)
MR. VOUDOURIS: Objection; form.
A. It is very likely -- it's lower power again, okay. It's very likely just underneath of this arrow that's a vessel. Even red blood cells inside. Okay.

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But we can confirm, you know, using microscope.
Q. (BY MR. THORNBURGH) So you'd need -- you would need to confirm that by looking at a higher power?
A. Yeah.
Q. Is that true for -- strike that.
Higher power -- power would allow you to give a more reliable --
A. Estimation.
Q. -- estimation?
A. Correct.
Q. All right. Okay. Go to paragraph 2.
A. Paragraph 2. B?
Q. On Page 21 of Exhibit 2.
A. 21, okay.
Q. And this is where you discuss the erosion?
A. Yes.
Q. Okay. And you say that "Dr. Iakovlev notes the mucosal erosion in Ms. Corbet's explanted mesh by showing interrupted squamous mucosa and granulation tissue and mixed inflammation" [as read].
And then you cite to CK -- his Figure CK1c, right?
A. Correct.
Q. And you -- you essentially say that while there is a clinical finding of erosion -- in other

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words, Dr. Smith found an erosion upon examination -- you don't believe that there is an erosion identified or observable on CK1c of his report, right?
MR. VOUDOURIS: Objection; form.
A. Yeah.
MR. VOUDOURIS: Go ahead.
A. Pathologically, this picture, his CK1a picture, is very fragmented, okay? Do you see that?
Q. (BY MR. THORNBURGH) And we're talking about CK1c, right?
A. 1a. 1a.
Q. 1a and c? Okay. Let's look a and c.
A. I would say 1a, b, and c, right?
Q. Okay. So if you go to Page 99 of his expert report, right?
A. Right.
Q. He says "Mucosal erosion site." And he uses H&E staining?
A. Right. And then, based on these pictures, no pathologist can say this is the erosive site because these tissues are fragmented.
Q. What do you mean by that?
A. You see multiple pieces. They are not intact tissue. Right? Do you understand?
Q. All right. So your -- it's your opinion that

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no -- no pathologist could find an erosion on this -- this specimen because they're fragmented?
A. Yeah. Because nobody can say, based on these findings, that represent erosive site.
Q. What about on CK1c?
A. CK1c, we have squamous mucosa, right, and underneath of the mucosa, we have, yes, mixed inflammation. That, I agree. Lots of inflammation there, okay? This area we can say is moderate. That's fine. Okay. And then there is underneath another picture showing like lamina propria or fibroconnective tissue underneath. You see this?
Q. Okay.
A. And then -- however, these three pictures do not show any mesh fiber. Where is the mesh?
Q. Okay. But you do see the -- the mucosa's there, right?
A. Mucosa is there.
Q. And that -- that's what -- where the mesh would have eroded through?
MR. VOUDOURIS: Objection; form, foundation.
A. Mucosa is part of the vagina, and Dr. Smith trim and excised a portion of the mesh, right? And if you want to demonstrate this is the erosive site, you

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have to show immediate adjacent to the mucosa you have mesh. Then that means it's exposure. Do you understand?
Q. (BY MR. THORNBURGH) I think I understand what you're saying, but I thought you agreed, though, that at the site of erosion, you would get a heightened level of inflammatory response, right?
A. That's fine, yeah. Yes. Most of the case, yes, they have enhanced level of inflammation.
Q. And you'd agree that on CK1c, these slides demonstrate an enhanced moderate inflammatory response?
A. Compared to the remaining specimen, yes, more inflammation's found in this area.
Q. And are those -- do you see acute, or do you see chronic inflammatory response?
A. We have both acute and chronic. That's so-called a mix.
Q. And how do you see acute?
A. Acute is neutrophil and chronic is lymphocytes.
Q. And how are those two things colored differently on -- or stained differently on your -- on that --
A. Because in this level, you are not able to tell. They all become black box. You have to magnify

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to higher magnification. Then we are able to tell.
Q. So on Page 101, CK1c, you are agreeing that there is chronic inflammation observed there of a moderate level, but you just can't offer an opinion -- you can't state to a reasonable degree of medical or scientific probability that this is the site of the erosion?
A. Correct. Because if I were Dr. Iakovlev, I will take very low power to show the whole picture, where is the mesh, where is the mucosa. Then, that's a good demonstration. But he didn't. Why he didn't, you can ask him.
That's why I say there is no convincing evidence from pathological point of view there is erosive site, but I did not disagree with Dr. Smith's finding in the clinical side. It's different -- two different issue.
Q. Okay. If you go on to 3 -- paragraph 3 -- let me as -- well, strike that.
Before I go there, did you -- have you asked to look at the microphotograph -- strike that.
Have you asked to look at, or did you look at, in rendering your opinions in this case the slides that were evaluated by Dr. Iakovlev?
A. When I read these slides, I think before I

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read these slides, then Dr. Iakovlev already read. He read first.
Q. Okay. But you didn't actually get a slide -- the slides that Dr. Iakovlev had and looked at those slides under a microscope; you're just looking at his photomicrographs?
MR. VOUDOURIS: No. Objection.
A. No.
MR. VOUDOURIS: He did look at the slides.
A. I did look at the slides. I did look at the slides.
Q. (BY MR. THORNBURGH) Okay. That's why -- I just -- I'm trying to understand that.
A. The slides are identical slides.
Q. Okay. So did you try to find the slide that we saw on CK1c and take a photomicrograph of it in a larger or a lower magnification?
MR. VOUDOURIS: Objection; compound.
A. I see this inflammation, but the -- I think, based on my memory, the mesh fiber is away from this site. It's not really immediately adjacent to the mucosa.
Q. (BY MR. THORNBURGH) Because earlier you testified if you were Dr. Iakovlev, you would look at that slide and zoom out so that you could see where the

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mesh fibers are, right?
A. Yes.
Q. Did you do --
A. If -- if I believe this represents the erosive site or exposure site, I will take a lower power picture, then have the high power picture to show.
Q. Despite that you had the same slides, you didn't do that in your -- you didn't take --
A. Because there is no evidence.
Q. Okay. But you didn't -- you didn't demonstrate that in a photomicrograph attached to your expert report, right?
A. Because there is no evidence of erosive site can be demonstrated from the slides. That's why -- what's the reason I take a picture for that?
Q. It's a heightened, mixed inflammatory response mucosa.
A. I acknowledge that, that the --
MR. VOUDOURIS: Objection.
A. -- focal area has that.
Q. (BY MR. THORNBURGH) All right.
A. You understand, right?
Q. Yeah. Your opinions in paragraph 3 --
A. Okay.
MR. VOUDOURIS: We're on page...?

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MR. THORNBURGH: Page 21 still.
Q. (BY MR. THORNBURGH) You say "Dr. Iakovlev identifies diffuse scar tissue by showing multiple histological pictures" [as read], and then you provide a list of different figures that are in his report. Then you opine that his interpretation is incorrect, and you -- and you state that the basis for that is that his report clearly shows viable fibroblasts within the collagen, right?
A. Correct.
Q. And then you said that means the presence of mild to moderate degree of fibrosis?
MR. VOUDOURIS: Without mature --
A. Correct.
MR. VOUDOURIS: -- or pure scar tissue.
Q. (BY MR. THORNBURGH) -- without mature or pure scar tissue.
So is it -- let me just understand. If I -- understand your opinion correctly, you agree that there's a mild to moderate degree of fibrosis observed within CK2a, 2b, 2c, 3a, 3b, and 4?
A. In the different --
Q. You're just -- but you don't believe it's a mature scar?
A. Yeah. In here and there, it's a focal area.

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You have -- a majority of them, they're mild; the focal area will be moderate. That's fine.
Q. Where -- which of those exhibits did you find -- I'm sorry. Let me ask a better question.
In those figures, did you find a focal area of moderate fibrosis in each one of those figures?
A. For instance, he labeled -- he --
Q. If could you identify the page number that you're on --
A. Okay. That's page -- Page 104. All right? And he labeled was a fibrous tissue, and in parentheses, "scar." Then again, he said, "Bridging or crossing a pore."
Actually, based on my understanding here, it is -- very focally, it's a moderate fibrosis. But in -- even if a moderate fibrosis you see immediate adjacent that there are multiple vessels. Then underneath, you have loose connective tissue.
Q. Okay. Can you circle for me the areas that you agree demonstrate focal moderate fibrosis?
A. These are the area of focal moderate fibrosis [indicating].
Q. And that's on Page 104, Figure CK2c, right?
A. Yes. And you have vessels, vessels, vessels [indicating].

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Q. Can you just -- if you go to 3a, CK3a?
A. Yeah. CK2a, 3a. Okay.
MR. VOUDOURIS: Page 105.
A. CK3a. Page 105.
Q. (BY MR. THORNBURGH) Page 105, yeah.
All right. Now, this says, "CK3a, tissue edema within mesh spaces, H&E, 20X objective, mesh filaments filled with yellow in the labeled copy of the image" [as read].
In these fields, there are areas of fibrous tissue where collagen is separated by empty spaces. Do you see any -- do you disagree with that statement?
A. Yes. Because I still disagree mainly because there is no way you can tell these are loose connective tissue versus edema.
Q. And what was the basis for that opinion?
A. Because it's just a -- you have a little bit of light space there.
Q. Because of the light space?
A. Yeah.
Q. Because of the stain -- the color of the stain?
A. Right. That's -- you have a whitish area. You don't know they are loose connective tissue or

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because of a watery kind of element there, so-called edema.
Q. Okay. So do you agree that there's edema identified in CK3a?
MR. VOUDOURIS: Objection.
A. I cannot be sure this is edema. And he interprets as edema, but if it was my opinion, I don't think I'm going to label this area represent edema.
Q. (BY MR. THORNBURGH) If you look at the image on the left on Page 105, CK3a, the very bottom --
A. Yes.
Q. -- underneath -- I'll point to you right here. This area here [indicating]?
A. Yes.
MR. VOUDOURIS: Which area are you pointing to?
MR. THORNBURGH: On the very bottom -- we can -- we can circle it.
Q. (BY MR. THORNBURGH) We'll circle on Page 105.
A. [Witness complies.]
Q. What do you see in that image?
A. That's still fibroconnective tissue with mild degree of inflammation.
Q. You called that mild degree?
A. Yes.

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Q. And all the -- all the little purple dots, what are those?
MR. VOUDOURIS: Objection.
Go ahead.
A. Purple dots? You mean black one here [indicating]?
Q. (BY MR. THORNBURGH) Black dots?
A. Yeah. Black dots --
Q. Look purple.
A. -- can be inflammatory cell. Also can be fibroblast, nuclei of the fibroblasts.
Q. Within that circle area, you're saying that's sparse, separated inflammatory cells?
A. Yes.
Q. If you turn the page to CK4.
A. CK4.
Q. It's on Page 107.
A. Yes.
Q. Okay. So you, again, disagree that this image demonstrates fibrosis?
A. We have certain degree of fibrosis, that's true. Probably is mild. But this is too -- magnify too high. You need an overall picture.
Q. In this picture, do you see moderate --
A. I don't --

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Q. -- fibrosis?
A. I didn't in that.
Q. What --
A. I do not.
Q. It says that there are lymphocytes identified within this image. Do you see the lymphocytes?
A. Yes. Lymphocytes, I agree.
Q. Now, and what is a lymphocyte an indication of in terms of the grading of fibrosis?
A. It's -- it's a main component of the inflammation. So the amount of lymphocytes, people use that to judge the grade of the inflammation.
Q. And the presence of lymphocytes makes the severity of the inflammation greater?
MR. VOUDOURIS: Objection; form.
A. No. Lymphocytes almost -- is very commonly present adjacent to these mesh fibers. That's a part of the normal tissue response.
Q. (BY MR. THORNBURGH) Normal tissue response to --
A. To implants.
Q. -- foreign body?
A. To foreign body implants.
Q. Did you see, either in the slides that are contained within Dr. Iakovlev's report or within your

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own report, any evidence of nerves with -- in between pores?
MR. VOUDOURIS: Objection; form.
Q. (BY MR. THORNBURGH) Or nerve distortion?
MR. VOUDOURIS: Objection; form.
A. I did not see any nerve distortion, number one. Number two, I didn't observe focal area of nerve fibers adjacent to the mesh fiber spaces.
Q. (BY MR. THORNBURGH) And when I say "distorted" -- "distorted nerves," what's -- what does a distorted nerve look like?
MR. VOUDOURIS: Objection.
Q. (BY MR. THORNBURGH) Does it bend?
MR. VOUDOURIS: Objection; form.
A. Based on my past experience practicing pathology over 20 years, all right, I see normal nerve endings or fibers in the vaginal tissue. They all look similar like this; therefore, there is no evidence there is an abnormal -- abnormality.
When you say "distortion," basically, it's one of the form. I -- I don't think any pathology -- you know, a typical pathology textbook will describe as a distortion.
Q. (BY MR. THORNBURGH) Let's look -- if you look at Page 109, CK5b, Dr. Iakovlev's report. And do you

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see the --
A. The nerve.
Q. -- nerve that's identified?
A. Yes.
Q. You agree that's a nerve, number one, right?
A. Oh, yeah, sure.
Q. And is that within the fibroconnective tissue near the fibers?
MR. VOUDOURIS: Objection --
A. Near the --
MR. VOUDOURIS: -- form.
A. -- filaments.
Q. (BY MR. THORNBURGH) Near the filaments?
A. Yes.
Q. And -- and you don't believe that that nerve is distorted in any way?
A. No; not at all. Because it's a common finding, this shape, because depending on the cut.
Q. Depend --
A. The tissue.
Q. -- depending on the cut of the --
A. Of the tissue.
Q. -- tissue?
A. Yeah.
Q. Okay. Let's look at some of your slides real

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quick. Let's go to Page 12.
A. From my own report?
Q. Yeah. Yeah, your report, Exhibit 2, Page 12.
MR. VOUDOURIS: Exhibit 2?
MR. THORNBURGH: I think it's Exhibit 2, right?
MR. VOUDOURIS: Oh, I thought you were referring that it says on Page 12, Exhibit 2.
MR. THORNBURGH: No, no.
MR. VOUDOURIS: I know what you're saying. I apologize.
THE WITNESS: My report, Exhibit 4.
MR. VOUDOURIS: Your report is Exhibit --
THE WITNESS: -- 4.
MR. THORNBURGH: Oh, Exhibit 4?
MR. VOUDOURIS: Yes. Exhibit 2 is the hard drive --
MR. THORNBURGH: That's right.
MR. VOUDOURIS: I'm sorry -- is the disc, yeah, portable disc.
Q. (BY MR. THORNBURGH) So Exhibit 4, your expert report, go to Figure 3.
A. Figure 3, yes.
Q. And now, you have -- this is a low magnification --

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A. Yes.
Q. -- 20 times, 20X?
A. Right.
Q. And you include -- let me ask you this question: How many microns, i you know, from the mesh fiber -- is that -- strike -- strike it. Let me ask a better question.
You have M there. You see the M?
A. Right. M is mesh fiber spaces, yes.
Q. So you have -- you say mesh -- M labels the mesh spaces?
A. Yes.
Q. Okay. So -- because that looks like a mesh fiber to me, not a space.
A. Because -- it's a space because the real mesh is sloughed after tissue processing.
Q. Okay. So that's where the mesh --
A. Located originally --
Q. -- fibers were located?
A. -- in vivo.
Q. That's where the mesh fibers were located in vivo, right?
A. Correct.
Q. So that's not really -- that's not a pore there; that's actually the mesh fiber?

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A. Right. It's a -- it's a cluster of the mesh. It is in knots basically.
Q. Okay. And then you have -- this image includes a considerable amount of tissue without mesh in it, right?
A. Correct. That's adjacent -- so-called adjacent fibroconnective tissue excised by Dr. Smith.
Q. Okay. Do you know what the distance in -- approximately, in microns, is from the --
A. This is not microns. Several millimeter.
Q. Several millimeters?
A. Okay. Because the lower power -- 2X lower power, 20X lower power. The whole field is about 1.1 centimeter. So this is cut like from mesh to this area at least a 5 millimeter [indicating].
Q. Okay. So it's at least 5 millimeters of tissue that significant -- a vast majority of the image doesn't show tissue that had mesh in it, right?
A. Correct.
Q. And when you look at a slide, you look at it at a low -- a low power, like 20X, or even lower, right?
A. No, just lower first, then higher. Usually lower will show overall picture. Then can magnify to show what the representative area from the slides we

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want to show.
Q. Okay. And so when you graded this sample -- or this slide, for inflammation, you included several millimeters of tissue that wasn't even near the mesh, right?
A. I --
MR. VOUDOURIS: Objection; form.
A. I included both immediate adjacent to the mesh and the tissue away from the mesh. So this picture, I say, barely shows any inflammation in this area, in the several millimeter tissue -- several millimeter away from the mesh fiber.
Q. (BY MR. THORNBURGH) So the area further -- furthest away -- so on exhibit -- Page 12, Figure 3, you say barely shows any inflammation in these areas, and that's the area that's furthest away from the mesh fibers, right?
A. Correct.
Q. And as you get closer and closer to the mesh fibers, you get a greater and greater inflammatory response?
A. It's not greater and greater. Still minimal is there. You can see still is a bluish area adjacent to the mesh fiber. That's minimal. It's mild.
Q. It's --

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A. Yes.
Q. -- minimum when you take the entire slide into consideration?
A. Correct.
Q. Including slide -- including tissues that are several millimeters away from the actual mesh?
A. No. I -- I clearly separate them. If several millimeter away from the mesh, basically no inflammation. And then mild -- majority of them, mild inflammation is present. Mostly immediate adjacent to the mesh fiber. It's clear, right?
Q. Well, I don't know about that.
A. Okay.
MR. VOUDOURIS: Objection; move to strike.
Can we go off the --
Q. (BY MR. THORNBURGH) But that's what --
MR. VOUDOURIS: Can we go off the record for one second?
MR. THORNBURGH: Yeah.
THE VIDEOGRAPHER: We're off the record at 3:46 p.m.
(Break taken.)
THE VIDEOGRAPHER: We're back on record at 3:58 p.m., beginning tape 4.
Q. (BY MR. THORNBURGH) Okay. Doctor, before we

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went off the record, we were looking at Exhibit 4, your expert report and specifically Figure 3, right?
A. Yes.
Q. Which is 20X power, low power, right?
A. Yes.
Q. And I'm still a little bit confused on how you are -- how you are grading this slide. I think -- correct me if I'm wrong, but you look at the entire slide at low power, which includes tissue that is several millimeters away from the mesh fibers, and you calculate, by looking at -- looking at the entire slide, the number of inflammatory cells within the entire slide to reach your final grading of that slide. Is that accurate?
A. I think this picture I want to show you overall situation in the lower power, including mesh and tissue immediate adjacent to mesh and tissue several millimeter away from the mesh.
So I try to show you the overall situation of the specimen. This is a good way to show overall picture of the specimen rather than just magnify in a very focal area to show some very dense inflammation area.
So therefore, I think this -- this is the message I want to convey. All right? Yes, I based

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on -- when I grade, I separate them, you know, inflammation amount immediate adjacent to the mesh in which condition, and then tissue several millimeter away from the mesh in what kind of condition.
Q. Okay. And the reason I ask this question is because all of the images or figures that you have in your report are low power. The greatest power appears to be 40 power, 40X, right?
A. Yeah, because 40X is the maximum routinely used by pathologist. Pathologist do not routinely use oil lens. It's -- which is 100X. That means magnified to 1,000.
THE REPORTER: To one what?
THE WITNESS: 1,000 because --
MR. VOUDOURIS: 1,000.
THE WITNESS: 1,000.
Q. (BY MR. THORNBURGH) And -- and if I understand it correctly, that's how you -- you grade based on low magnification and come to a conclusion based on the morphological features of the entire slide?
A. That's not true because lower power is showing you better overall picture. And when I'm grading, I always turn on the higher power to confirm they are actually inflammatory cells.
Q. Okay. And by higher power, you mean 40X?

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A. Yeah. Higher power is -- highest is 40X.
Q. That's the highest you'll go?
MR. VOUDOURIS: Objection.
A. 40X means -- is 40 -- it's 400 basically. Because when we say 40X, we have two lenses close to the slide, and the other lens is close to the eye. Close to the eye, we always -- that's a 10X. You understand, right?
Q. (BY MR. THORNBURGH) I understand. If you look again just briefly at Exhibit 8 and go to Page 594, which is the Hill article.
A. Right.
Q. And you see the Figure 1 where they show examples of how they grade?
A. Yes.
Q. And they show examples of the -- of how they graded certain slides?
A. Yes.
Q. You would agree with me that that is -- that the researchers in the Hill article are looking at those samples greater than 40X?
MR. VOUDOURIS: Objection.
Q. (BY MR. THORNBURGH) Let me ask it a different way. You'd agree that, number one, it's a greater -- it's greater power than 20X?

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MR. VOUDOURIS: Objection.
Q. (BY MR. THORNBURGH) Right?
A. Yes, greater than 20X.
Q. And would you agree it's greater than 40X?
MR. VOUDOURIS: Objection.
A. I'm not sure, because what did they say? What's the magnification here? They did not -- in the Figure 11, they did not specify. Did you see any specification for the magnification?
Q. (BY MR. THORNBURGH) No. I'm just asking based on your knowledge, training, and experience what it looked like to you.
A. And based on my understanding, this one looks like -- yes, a 4X. That means -- my -- this picture is a 2X, 20X total. This one --
Q. This -- when you say "this picture," you're talking about Page --
A. My picture --
Q. -- 12?
A. -- 12, is --
Q. Figure 3?
A. Yeah. Figure 3 total is a 20X.
Q. Okay.
A. We are now -- all use a total magnification, 20X.

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Q. Okay.
A. And then here, most likely, is a 40X.
Q. Okay. So you believe, based on your --
A. Right.
Q. -- knowledge, training, and experience that --
A. Right.
Q. -- Figure 1 --
A. It's like a 40X. Then the (b) specimen probably about 100X. And then (c) specimen is also 100X.
Q. Okay. What about the (d) specimen?
A. (D) probably is, maybe, similar or even higher.
Q. 100X or greater?
A. 200X. And then (e) probably is lower, possibly is a 40X.
Q. (F)?
A. (F) is kind of similar to the (b) and (c). All right. That's based on my best judgment.
Q. And do you believe it was appropriate or inappropriate for the researchers in Hill to, for example, in Figure 1c, use 100X magnification?
MR. VOUDOURIS: Object -- objection; form, foundation.
A. That's perfectly appropriate because the

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reason they want to show is to show example of the degree of inflammation and the degree of fibrosis. So therefore, depending -- depending on the purpose, then use different magnification.
Q. (BY MR. THORNBURGH) Okay. And if you look at Figure 4 on Page 13 of your expert report, you say, "mesh with integrative fibroconnective tissue showing mild degree of chronic inflammation" [as read], right?
A. Yes. Right. Then this time --
MR. VOUDOURIS: There's no question pending. He just asked you if that's what you said.
Q. (BY MR. THORNBURGH) And then you have arrows where you say, "Mild degree of chronic inflammation seen in areas immediately adjacent to mesh filaments" [as read], right?
A. Correct.
Q. And -- and this is at 40X?
A. Correct.
Q. And did you grade the degree of scar -- or fibroconnective tissue? You say mild inflammation, but I don't see a grading for the fibroconnective -- what you call fibroconnective tissue.
A. Fibroconnective tissue. I think I overall mentioned we have mild degree of fibrosis.
Q. When you say "overall," what do you mean?

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A. That means this entire specimen.
Q. So --
A. And then --
Q. So -- so when you look at the specimen, you grade it as overall mild degree of inflammation, which takes into account the tissue adjacent and away from the mesh filaments, right?
A. Correct.
Q. What about the degree of fibrosis closest to the mesh filaments, what is that level?
MR. VOUDOURIS: Objection; form.
A. Based on this picture, like on Page 13, my report, Figure 4, this is still mild degree.
Q. (BY MR. THORNBURGH) Okay. So let's make sure that the record reflects -- if you circle this area over here --
A. Right.
Q. So go ahead and circle that. That's what you call mild fibrosis, right?
A. This one even no fibrosis this area [indicating]. And this area is mild, okay [indicating]?
Q. Well, let's go ahead and circle right here. What level of fibrosis do you see between those two fibers? It's clearly greater than the two that you just circled, right?

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MR. VOUDOURIS: Objection; form.
A. Yes. That's true, but this is so minor. It's a very focal area. I mentioned that in my report, focal area was moderate degree of fibrosis, so --
Q. (BY MR. THORNBURGH) Go ahead and circle that and identify that as you just did. If you could just write it up here so I can read it later on. So moderate degree of focal fibrosis, right?
A. Yeah.
Q. And that's an area that's closest to and between two fibers, right?
A. That's very common too, yes. Okay.
Q. And same over here, go ahead and circle that area, the area between those two fibers.
A. [Witness complies.]
Q. Okay. And you -- would you agree that that also is moderate degree of fibrosis?
A. As I said, yes, I agree, but it's a very common finding.
Q. Okay. Go ahead and identify that as moderate degree of fibrosis.
A. I already did.
Q. No. The second one we just talked about.
A. Merge together, right?
Q. Oh, so they're the same. You merge them together.

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So in between those two -- those pores closest to the fiber, it's your opinion that to a reasonable degree of medical probability that the degree of fibrosis between those pores is moderate?
A. That's fine.
Q. Would you agree that the severity of fibrosis is greater closest to the mesh filaments, mesh fibers?
MR. VOUDOURIS: Objection; form, foundation.
A. In general, yes. That's because that's the way tissue responds to mesh filaments. That's true.
Q. (BY MR. THORNBURGH) So that's something that would be common, right?
A. It's quite common.
Q. And expected?
MR. VOUDOURIS: Objection.
A. It's expected.
Q. (BY MR. THORNBURGH) If you go to Figure 5, here you say, "There are occasional foci of moderate degree of chronic inflammation found in the specimen" [as read], right?
A. Correct.
Q. And you have arrows pointing to the moderate degree of inflammation?

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A. Yes.
Q. Is that chronic -- moderate degree of chronic inflammation, also?
A. That's -- I said moderate degree, right? That's occasional foci.
Q. And is that common, to be -- a common finding on your mesh fibers?
MR. VOUDOURIS: Objection.
A. I should say majority of -- of the specimens contains mild degree of inflammation based on my past experience. And for this one, yes, we have focal area of moderate degree of inflammation.
Q. (BY MR. THORNBURGH) And that's closer to the fiber, right?
A. It's adjacent to the fiber.
Q. Immediately adjacent to the fiber?
MR. VOUDOURIS: Objection; form.
A. That depends how you define "immediate" because you still have some space between inflammation -- cluster of inflammatory cell and the mesh fiber.
Q. (BY MR. THORNBURGH) Okay. Then -- and then also on this image, Figure 5 on Page 14 of Exhibit 4, in your report, you say, "The mesh fiber spaces are visualized adjacent to the squamous mucosa" [as read].

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What's the significance of that finding?
A. That the squamous mucosa is the same, and then underneath you see mesh fiber space. That's descriptive of my finding.
Q. But then you -- but you say immediately after that, "This is an indication -- a probable indication of mesh site exposure" [as read], right?
A. Right. Then based on this finding, I think, in -- in conjunction with a clinical finding of mesh exposure, then possibly this picture will be much better than the picture Dr. Iakovlev showed.
Q. Okay. So can you go ahead and circle where you see with -- or just write with this pen where you see the squamous mucosa indicating probable mesh exposure?
A. It's already --
MR. VOUDOURIS: He already has an arrow there.
A. -- in my Figure 11.
Q. (BY MR. THORNBURGH) I don't see it. I'm sorry. Oh, down here. Well, it's just a -- can you just write there "likely erosion" there?
MR. VOUDOURIS: Objection.
A. What do you mean likely --
Q. (BY MR. THORNBURGH) That's a likely site of

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erosion, right?
A. I --
MR. VOUDOURIS: Objection.
A. I say -- let me see. One is located...
(Witness reviewed document.)
A. "Indicating a probable mesh exposure site."
It's very clear there. Why you want a separate --
Q. (BY MR. THORNBURGH) Because we've been doing this game, so --
A. You can do by yourself because this is just clearly there, then --
Q. I'll go ahead and do it for you.
A. Right.
Q. So -- so is it -- is it right --
A. It's not for me. You -- because I already indicated very clearly.
Q. I see. But I want to see --
A. Right.
Q. -- a precise location. So if I circle --
MR. VOUDOURIS: Objection.
Q. (BY MR. THORNBURGH) -- this area, is that the area that you see it, or is it this area [indicating]?
A. Yeah. There's arrow indicating this area is squamous mucosa.

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Q. Okay. So I'm going to try to accurately circle that where you just indicated, okay? Is that the area of likely --
A. It is squamous.
Q. -- of the likely erosion?
A. No. I just --
MR. VOUDOURIS: Objection.
Q. (BY MR. THORNBURGH) -- or exposure?
A. No. You don't understand. This is the squamous mucosa we found, okay? It's very tiny, all right? It's -- it's better than the picture Dr. Iakovlev showed because he showed a picture very fragmented.
And then I was looking very carefully because I noticed that clinically there is exposure site. So then underneath you see -- adjacent to this area, you see several mesh fiber spaces, right?
Q. (BY MR. THORNBURGH) Uh-huh.
A. And then there is a distance from mesh fiber spaces to this squamous mucosa is probably within a millimeter of distance.
Q. I got it.
A. Therefore, it's possible -- I didn't say it's definitive. It's possible this area represents exposure site.

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Q. Okay. So based on that evidence, the location of the fiber --
A. Yeah.
Q. -- to the identification of squamous mucosa --
A. Right. Because squamous mucosa, that's on the top.
Q. So does that give you the ability to say to a reasonable degree of medical probability or certainty that's the area where the exposure occurred?
MR. VOUDOURIS: Objection.
A. I say the probable or possible area. It's not like definitively -- there is no definitive evidence saying, you know, from the specimen I examined shows the mesh exposure or erosive site.
Q. (BY MR. THORNBURGH) Okay. I mean, you just -- you don't use the word "possible" in your -- in your report. You actually say probable?
A. Right.
Q. Okay. So do you agree that that's the probable location of the mesh exposure?
A. Right. That's -- that's clearly in my report, right?
Q. So I'm going to write "exposure" here, okay? On Page 14 of your report.
A. Should be probable exposure.

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Q. Sure. Did you see -- do you see any evidence -- strike that.
Okay. Figure 6 is -- I think that's your last figure, right?
A. There's more than that.
Q. So Figure 6, briefly, you said this is -- shows good tissue integration, right?
A. Yes.
Q. And then you point to vessels that are -- how many -- how -- what's the distance of those vessels outside of the --
A. It's less than a millimeter away.
Q. Okay. So -- so you say this is good tissue integration, and then you have arrows to the vessels. And is the basis for your opinion the presence of the vessels?
A. Presence of vessels and also viable fibroblasts and some nerve endings.
Q. What's the degree of fibrosis over here --
A. It's still --
Q. -- closest --
A. Yeah.
Q. -- closest to the mesh fiber?
A. So this still, overall, is mild in this area. And then -- except this area may be, if you want, is

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moderate.
Q. Okay. Can you go ahead and draw an arrow to that in the margin so we can see it?
A. Right in this -- overall, this large amount of area there, all mild.
Q. What's your basis for stating that this -- these areas that you circled are mild?
A. Because you have viable fibroblasts and also vessels in it. And then you have, compared to other tissue away from this area, without any fibrosis here, you have more fibrous collagen.
Q. Furthest -- further away from the mesh filaments, right?
A. Right. Further away from mesh filaments, there is no fibrosis.
Q. And not in between -- the space between the pores?
A. Space between the pores, most of them, they are still mild, but only very focal area, very close area, you have some moderate degree, but it's --
Q. But that's --
A. -- it's a tiny, tiny place.
Q. You don't see vessels in between the mesh pores? You've drawn arrows to -- for, but you haven't drawn any arrows between the mesh pores, right?

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MR. VOUDOURIS: Objection; compound.
A. And there is another one. If you want, this is another one. Because there is no reason to indicate every single vessels in it. Overall situation, if you are trained pathologist, they're easily understand these area they're healthy. They have innervation, as well as a vascularization; therefore, they are viable tissue.
Q. (BY MR. THORNBURGH) Is it your opinion that the -- that the tissue over here where you've pointed to the vessels, which is a lighter color stain --
A. Right.
Q. -- is a better, more viable tissue than the tissue that is closest to the mesh --
A. They're all viable so far.
Q. Which tissue looks healthier to you?
MR. VOUDOURIS: Objection; form.
A. These are all healthy tissue look for me.
Q. (BY MR. THORNBURGH) So -- so are you stating that this area right here next to where you -- where you have the arrows to the vessels further away from the fibers is the same type of reaction that you're seeing closest to the fibers?
MR. VOUDOURIS: Objection; form.
A. It's very much similar but just a less degree of fibrosis.

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Q. (BY MR. THORNBURGH) Greater degree of fibrosis closest to the fibers?
A. We already say that.
Q. That's a common finding?
A. Yeah; it's a very common finding.
Q. Figure 7, you say -- so this is your S-100 comparison to H&E?
A. Yes.
Q. And -- and what are you trying to demonstrate in this -- in this exhibit, this figure on Page 16?
A. The overall demonstration point is amount of nerve fibers identified in the specimen is within normal limits.
Q. And normal limits compared to what?
A. I mean, it's a normal finding. Vaginal tissue should have no fibers.
Q. So you're not surprised to find nerves near mesh fiber?
A. Not at all. If I don't find any, then probably is a problem.
Q. Is it -- let me try and understand quickly about your opinion regarding pain and the finding of nerves.
MR. VOUDOURIS: Dan...
Q. (BY MR. THORNBURGH) Is it -- is it your

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opinion in this case, in Mrs. -- in Mrs. Corbet's case, that simply because there are nerves within a mesh specimen and nerves near the mesh fibers that -- strike that.

You're not saying, I don't think, that the presence -- strike that. Let me ask a better question.

You're not offering an opinion that nerve damage in Mrs. Corbet's case didn't lead to her pain, right?

MR. VOUDOURIS: Objection to form.

A. First of all, I never say that --

MR. VOUDOURIS: And you're misrepresenting what he said.

A. First of all, I never said -- said that there is any evidence of nerve damage, number one. Number two is presence of nerve in these specimen is a normal finding. Number three, from histological point of view, I can't say because presence of nerve in this specimen, that's correlated to patient pain. That's the three points I want to say.

Q. (BY MR. THORNBURGH) Okay. So essentially, I think, if I could just boil it down, it's your opinion that a pathologist can't opine that the clinical findings of vaginal pain are caused based on presence of nerve fibers found within a mesh specimen slide; is that

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correct?

MR. VOUDOURIS: Objection; form.

A. I only can say based on the finding of this particular case, there is no evidence for me to say these nerves' presence in the specimen predicts the pain in the clinical site. Is that clear?

Q. (BY MR. THORNBURGH) So you're not saying that the presence of nerves within or around the mesh doesn't cause pain.

MR. VOUDOURIS: Object.

Q. (BY MR. THORNBURGH) It can cause pain, right?

MR. VOUDOURIS: Objection; form, foundation.

A. Let me explain to you in this way: Nerve -- peripheral nerve growth is part of the tissue integration. That happens almost to every patient who received vaginal mesh implants, okay?

So that means even without examining all -- majority of the implant, the mesh, then majority of these patients who received mesh implants, they do not complain pain. You understand the linkage, right?

So therefore, finding these pain -- these nerve in the specimen for Mrs. Corbet cannot predict or correlate or can say associate with the clinical complaint of pain. Is that clear?

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Q. (BY MR. THORNBURGH) I think so.

So you're saying, I think, that you can't reliably look at a mesh specimen and see nerves present in or around Ms. Corbet's mesh and conclude that it's the presence of the mesh is causing her pain?

MR. VOUDOURIS: Objection; form.

A. Nobody can --

Q. (BY MR. THORNBURGH) Presence of the nerve --

A. Yes. I can't, and I don't think any other pathologist can.

Q. Is it possible for Mrs. Corbet that the presence of nerves in and around her mesh contributed to her pain?

MR. VOUDOURIS: Objection; form, foundation, and asked and answered.

A. You're asking a hypothesis or assumption. I -- I don't know how to answer that question.

Q. (BY MR. THORNBURGH) Well, what are the -- for Mrs. Corbet what are the potential causes of her pain, which led to the explant of the TVT device?

MR. VOUDOURIS: Objection; form, foundation, beyond his scope.

THE WITNESS: That -- that means I don't have to answer?

MR. VOUDOURIS: Well, you've already --

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you've already testified that you can't look from a pathologist's point of view --

THE WITNESS: Right.

MR. VOUDOURIS: -- at the slides and correlate it with a complaint of pain.

Q. (BY MR. THORNBURGH) So you can't, and won't at trial, offer an opinion to a reasonable degree of medical certainty what the cause of Ms. Corbet's pain is, correct?

MR. VOUDOURIS: Objection; form, foundation.

A. I'm not in the position to explain where is the source for this patient of dyspareunia she complained because based on pathological findings, I do not see any evidence to correlate to the pain. That's the statement.

Q. (BY MR. THORNBURGH) And I just want to make sure I understand. You also didn't find any other pathological finding, like a tumor or something else, that could be causing her pain, correct?

A. Yeah. If I see --

MR. VOUDOURIS: He just -- he just asked you if you did or didn't.

A. I didn't. But if I see a neuroma, for instance, then, that could be a reasonable finding to be

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associated with the pain.
Q. (BY MR. THORNBURGH) Okay. And you said neuroma?
A. Yeah.
Q. What's a neuroma?
A. It's a -- it's a tumor of the nerve.
Q. So you didn't find any sort of -- there was no pathological findings like that --
A. No.
Q. -- that would explain her pain?
A. Correct.
Q. The only finding you have and have demonstrated in these figures that you've attached to your report are mesh explant specimens that contained mesh, right?
A. Yeah.
Q. Some with occasional -- with increased inflammatory response around the mesh fibers compared to the further adjacent tissues?
MR. VOUDOURIS: Objection.
A. My conclusion is in my report, all right? That's clearly --
Q. (BY MR. THORNBURGH) But my question is: You didn't find any other pathological findings that could explain pain, but you did find the presence of mesh,

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nerves near the mesh, you found inflammatory response, and chronic foreign body reaction, correct?
A. Correct.
Q. It's not possible for you, as a pathologist, to say that those findings are causing her complications, including pain, right?
MR. VOUDOURIS: Objection; form, foundation, asked and answered.
A. Correct. And also nobody -- no other pathologist can predict that based on these histological findings.
Q. (BY MR. THORNBURGH) Didn't Hill and his coauthors identify women who had pain and associated increases of inflammation and chronic foreign body reaction?
MR. VOUDOURIS: Objection; form.
A. I'm not sure for that particular point, but if you have read in -- you know, you can just read.
MR. VOUDOURIS: Audra Jolyn Hill might be a little disappointed that you referred to her as a he.
Q. (BY MR. THORNBURGH) Mrs. Hill --
MR. VOUDOURIS: No. Dr. Hill.
MR. THORNBURGH: Dr. Hill.
Q. (BY MR. THORNBURGH) Dr. Hill found that for nearly 60 percent of the patients who had mesh

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explanted, there was moderate fibrosis, right?
A. That's depending on what kind of condition they -- these individual patients had.
Q. For all -- all three groups, there's no significant difference, remember?
A. I -- I know that. But for this particular patient, we do not see -- mainly, it is a very focal area with moderate amount of information. The majority of them, they are mild; and many areas, no inflammation.
Q. On Figure 8, you have an image. It looks like the same image with different stains and different --
A. Magnification.
Q. -- magnification --
A. Yes.
Q. -- is that right?
And you have a square representing where you've magnified the image?
A. Correct.
Q. Okay. And so in exhibit -- or in Figure 8a, that's just the trichrome stain, right?
A. Correct.
Q. You're not offering any opinions based on that; you're just showing what a trichrome stain of this slide looks like?
A. No. I want to show because Dr. Iakovlev

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showed very lower power use trichrome stain, says because all these blue color represent the fibrosis. Therefore, he conclude these are the severe fibrosis or scar everywhere. Then I try to show the same area from the slides he took the picture then magnify gradually to see these are not scar tissue. That's the point I want to show.
Q. Okay. So Figure B is a -- what magnification, on Page 22 of your report?
A. B are probably -- panel A is 40X, then panel B is a 40X too.
Q. And that's 40X in H&E, right?
A. Right.
Q. Okay. And then you -- and what's the distance from the fiber to that area, which looks like it's --
A. It's within less than a millimeter. It's only maybe half a millimeter away.
Q. 500 microns or so?
A. Yeah. You can see the mesh fiber is about maybe 100 -- 100-micron cross-section diameters; therefore, you only have 2- to 300 microns.
Q. So it's not -- it wouldn't be immediately adjacent to the mesh; it would be further out?
A. It's 2- to 300 micron. Basically, it's quite close already. It's a micron level.

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Q. And it's not in between the mesh pores, right?
A. It's -- it's not mesh pores.
Q. It's outside of the mesh pores, correct?
A. It's -- could be still within the pore because, as I said, two-dimensional pictures, you can't tell within the pore or it's outside the pore or adjacent to the pore. So basically, what we candidly describe is adjacent to the mesh. You understand?
Q. Well, I don't understand how it could be within a pore. Because if we look at your images, right, look at --
A. That's --
Q. -- look at B --
A. Right.
Q. -- it -- it showed -- it appears to show that it's -- it's not between these two pores if it's not on the slide.
A. It's adjacent to the pore.
Q. It's adjacent, but not in between.
A. Doesn't matter. In between is theoretically also adjacent; because in between, that is not necessary it's within the pore.
Q. Well, do you see any other pores on this side adjacent to the -- the microvessel that you've circled there or squared there?

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A. Here is a -- is a space. So I don't know what kind of space is that.
Q. Does it look like a pore?
MR. VOUDOURIS: Objection.
Q. (BY MR. THORNBURGH) It's too big to be a pore in that space, right?
A. No.
MR. VOUDOURIS: Objection.
A. No. This is the tissue, missed portion of the tissue there.
Q. (BY MR. THORNBURGH) You're not going to -- you're not representing to the Court or to the ladies and gentlemen of the jury, and won't at trial, that this microvessel is in between the mesh pores, right?
A. What -- you see the Figure A, panel A, is a trichrome staining, right, it's a lower power trichrome staining. In the center, that's mesh fiber spaces. Then adjacent, they are all fibroconnective tissue, right?
Q. Yeah. I'm just -- I'm just going to make -- I'm just making sure that at trial you're not going to suggest or represent to the Court or opine or offer an opinion that this microvessel is in between pores, is filling the space of --

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A. I didn't say that. I said just -- the tissue immediate adjacent to the mesh fibers, they represent integrated tissue instead of pure scar. That's the point.
Q. Does it appear that this is closest to the edge of the scar rather than the center of the --
A. This is not the scar.
Q. -- fibroconnective tissue?
MR. VOUDOURIS: Objection; form.
Q. (BY MR. THORNBURGH) Let me ask it again. Does it appear that this -- this area that you've identified as a microvessel is -- is closer to the edge of this fibroconnective tissue?
A. It's not -- this specimen just like this area, okay [indicating]? Okay, like panel A. And because different levels and you show these area, Dr. Iakovlev says they are all scar tissue.
And my point is, these area, they not scar tissue. Because if you magnify a little bit, you can see viable vessel, as well as viable fibroblasts; therefore, they are not scar tissue. That's the point.
Q. Figure 9 -- when you say "scar tissue," you're not -- are you saying they're not mature --
A. They're not pure scar.
MR. VOUDOURIS: Objection.

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Q. (BY MR. THORNBURGH) Pure scar. And pure scar would be?
A. Pure scar will be just like Dr. Hill say, like this picture [indicating].
Q. Okay. So how long -- do you know how long -- how -- strike that.
You don't know how long this mesh was implanted in this particular patient, right?
A. He -- she only presented as an example.
Q. And by "this particular patient," I'm talking about this figure --
A. We don't know what kind of condition.
Q. -- Figure E on Page 594 of Dr. Hill's article, right?
A. Right.
Q. And how long was Mrs. Corbet's mesh implanted in her?
A. It's about one year, right?
Q. July 2011 until early 2013?
MR. VOUDOURIS: February 2013.
A. It's over -- a little over a year.
Q. (BY MR. THORNBURGH) Approximately a year and a half?
A. Yeah.
Q. Okay. And you know from -- you understand

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that the tissue response is chronic and lasts for years?
MR. VOUDOURIS: Objection; form.
A. Assuming the foreign body there, usually, yes, you will -- will have more or less inflammatory response.
Q. (BY MR. THORNBURGH) Do you know how long it takes to get a -- what you call a pure scar tissue?
MR. VOUDOURIS: Dan, this was covered ad infinitum in his prior depositions.
MR. THORNBURGH: Okay.
Q. (BY MR. THORNBURGH) Do you have any opinions with respect to Mrs. Corbet, whether or not if the mesh had remained in her body for longer, that it would continue to experience increased inflammatory response and foreign body reaction?
MR. VOUDOURIS: Objection; form, foundation --
Q. (BY MR. THORNBURGH) It -- it would seem --
MR. VOUDOURIS: -- speculation.
Q. (BY MR. THORNBURGH) The foreign body response and inflammatory response would be persistent and remain constant for the mesh that's still in her body?
MR. VOUDOURIS: Objection; form.
A. I'm not able to predict the things is not happening yet, first of all. But in general, yes, if

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you have implanted the mesh, then inflammatory response or tissue response will continue.
Then the degree of -- of inflammation or degree of fibrosis, that's individualized rather than just you can draw an equation that says how many days there then will reach to a certain level. No. Every patient is different.
Q. (BY MR. THORNBURGH) Your -- your Figure 9, the -- the images that you took, is a section that you're -- you've sort of dedicated to the degradation or your opinions concerning degradation?
A. Concerning his so-called bark-like area, right?
Q. Yes. On Page 24, you've got image A, B, and C, and you took that in a low magnification, right?
A. It's not really low. You can see.
Q. What's the magnification on exhibit A, B, and C?
A. Did I say that? Oh, no.
Q. No.
A. Based on this one, most likely will be 40 or 100.
Q. Did you take any additional images with higher magnification to get closer to the edge of the mesh fibers?

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A. I think like this, the Figure 11, is higher magnification, which is at least 100 or 200. Okay?
Q. You could have gotten closer on that magnification, right?
A. And because usually closer is not that good. Because here, you can see clearly to see the illustration between the true mesh versus bark, all right? Everybody can see very clearly. That's the point. If it's not very clear, then I will actually magnify to make it clear.
Q. If we look at, for example, Page 60 -- hold on a second -- 24 of Dr. Iakovlev's report.
A. Page 24?
Q. Uh-huh.
MR. VOUDOURIS: What page? I'm sorry.
MR. THORNBURGH: 24 of -- I'm sorry -- 65, image 24b.
MR. VOUDOURIS: Page --
MR. THORNBURGH: 24b.
MR. SNOWDEN: Counsel, do you want to use the Corbet portion of deposition or no?
MR. THORNBURGH: I was going to ask what the magnification is on -- on this image.
MR. SNOWDEN: Is that for Ms. Corbet?
MR. THORNBURGH: I'm comparing to the

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magnification that he used in his report.
MR. VOUDOURIS: Yeah, so --
MR. THORNBURGH: I'm just -- I'm just asking him --
Q. (BY MR. THORNBURGH) This magnification on Page 65, in 24b is a higher magnification than what you used in Figure 9, right?
A. That's a lot higher.
Q. Okay. And how much higher; do you know?
A. I don't know. Maybe still like either solvent, something -- oil lens. That's the tool he likes to use.
Q. If you turn to Page 116 of Dr. Iakovlev's report, Figure CK8b, this is an image of Ms. Corbet, right?
A. Yes.
Q. Okay. Do you -- that's a much higher magnification than you used --
A. Right.
Q. -- in your figures -- the figures contained within Figure 9 and Figure 10, right?
A. Right.
Q. And if the bark or the surface layer of -- surrounding the mesh fibers is 2 to 5 microns, wouldn't you agree that to get a better image, you need

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to have a stronger-powered zoom?
A. No.
MR. VOUDOURIS: Objection; form, foundation.
A. I disagree because the point here is if these bark-like material, they represent degraded mesh material, then under the polarized condition, they will show identical birefringing condition. That's the point I want to show.
And what he wants to show is a very high magnification is to show these cracks-like stuff there, all right? And which is usually -- I don't like to use this kind of very high magnification.
If they do want to show, then he should include a lower magnification, show the area he's pointing. That will be much better picture than to demonstrate some points, right? Even I don't know where this coming from. If you show higher magnification from -- for instance, if I show my finger is blown into 1,000 times, nobody can tell this from my finger.
Q. (BY MR. THORNBURGH) So you think it would be better for him to start out --
A. Right. Start it from lower power, then gradually --
Q. Zoom in?

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A. Right. Okay. So this point, I use the intermediate power is simply try to demonstrate one is -- clear-cut is a mesh, remaining mesh, right, in the -- in the center. You see the different color and the different -- one is blue, one is yellow, the other is green.
Q. Uh-huh.
A. Why is that? Because in the polarized condition, these mesh fibers show polarized or birefringent property, right? And then --
Q. Uh-huh.
A. -- the bark material he claim -- and whatever he claim, that they -- all these bark represent degraded mesh, they should have showed similar birefringent property. But this picture shows opposite.
Q. How many filters did you use, polarized filters?
A. How many filters?
Q. Yeah.
A. What do you mean? It's a typical, standard birefringent -- polarized filter.
Q. So it's one -- one polarized filter?
A. Yes. One is on the top, the other is --
Q. On the bottom?
A. -- on the bottom. Right. It's a standard

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pathology practice.
Q. Did you use oil immersion?
A. No. As I said, surgical pathologists, the highest magnification is 400. And the oil immersion is for microbiologist or cytopathologist.
Q. So -- so you didn't use oil immersion because you're only going to look at the specimen using 40 magnification?
MR. VOUDOURIS: Objection; form.
A. 400 -- highest is 400.
Q. (BY MR. THORNBURGH) So -- so the reason why you didn't use oil immersion is because you were only going to go as high as -- you say 400, but are any of these 400?
A. These are not hundred, but can be -- can go to -- highest is 400. It's really not necessary to use oil immersion lens.
Q. Unless you're going to do a higher magnification?
A. For me, there is no point to do that; no point to go further high.
Q. So, you know, on Figure CK8b on Page 116, Dr. Iakovlev says that he -- this was a degraded layer of bark, polypropylene, seen using H&E 100X subjective with oil immersion polarized light.

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A. Right. He --
Q. This indicates he's using 100X, right?
A. 100X means to 1,000 magnification.
Q. Okay. And your magnification was as high as what on these images in Figures 9 and 10?
A. That's why I -- that's how I say probably is -- maximum is -- is 100.
Q. So that would be 4X and 10X?
A. It's either 4X or 10X then become either 40 or 100.
Q. Did you attempt to go to 1,000 magnification or 100X?
A. There is no reason to do that. That's why I say -- if I magnify too high, then the remaining tissue, you cannot see. Even if the -- then people can ask me, "Where this coming from?"
Q. Okay. So -- and that's why you didn't use oil immersion because you don't --
A. Right. That's why -- that's the same question I'm going to ask you: "Where this coming from?" I don't know.
Q. Let me finish the question. You didn't -- you didn't use oil immersion because you weren't going -- going to magnify up to 1,000?
A. There is no reason --

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MR. VOUDOURIS: Objection.
A. -- as I said.
Q. (BY MR. THORNBURGH) Have you ever -- strike that.
Did you place the polarized -- hold on a second. Strike that.
Dr. Iakovlev, on -- on Page 116, says, "If there is an object with polarizing properties between the filters, the light plane deviates from the perpendicular plane, and the object becomes visible" [as read].
Do you see that?
A. Which line is that?
Q. So let's -- let's go a couple lines. So if you go to "When two polarizing filters were placed above and below the glass slide" [as read].
Do you see that last sentence?
A. Okay. The second line, yes.
Q. -- "and their polarizing orientation is perpendicular, their light cannot pass through. However, if there is an object with polarizing properties between the filters, the light plane deviates from the perpendicular plane, and the object becomes visible" [as read].
Do you have any basis to disagree with

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that statement?
A. This is fine because these are the polarized, the -- the nature of the polarized lens, when you use that, and you can see these things.
Q. Did you use that same method when you did the polarization --
A. Yes.
Q. -- in Figure 9 and 10?
A. That's routine practice for pathology.
Q. Why -- why is -- why are his images darker than your images?
MR. VOUDOURIS: Objection.
Q. (BY MR. THORNBURGH) Is there a way to add additional -- to keep -- to continue to polarize the -- the filters to get a different image like he's got on figure CK8b?
MR. VOUDOURIS: Objection.
A. Polarize the condition. If you turn the polarized lens a little bit, like 5 degree, then you see different picture, different color, okay? Then why this is black -- and first of all, I don't know where this coming from, number one. All right?
Number two, he say that there is H&E associated. Where is the H&E?
Number 3, all these so-called cracks-like

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things he use or arrows indicate that. This could be -- well be like artifact we just discussed earlier in the morning through the blades. We don't know what's going on for this one. So there -- this picture did not demonstrate anything at all for me.
Q. (BY MR. THORNBURGH) Are you claiming that those cracks that we see on the outer surface of this fiber is artifact?
A. We don't know what -- I did not claim. As I said, there is a possibility because nobody can confirm what are those stuff.
Q. Okay.
A. Because you magnify to the 1,000 times and then to see a very tiny area showing these so-called irregularity, or these lines, on the surface of the polymer fiber.
Q. You keep on saying we don't know where this image is coming from, but he's identified that in -- on Page 116. You see that, right? The same fields are in CK5a.
A. I know. I would say that where this coming from, CK5a is of which -- corresponding to which picture of the -- of the H&E slide.
Q. So are -- let me just make sure I understand. Are your criticisms that, number one, you don't know

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where this fiber is coming from, this fiber image?
A. Right.
Q. Number two, he used 100X objective --
A. Right.
Q. -- to get close up on the image?
A. That's very high. That's 1,000 times magnification.
Q. And what are your other criticisms of this image?
A. And then his -- his arrows indicating -- let's read -- what's the -- arrow indicating what?
(Witness reviewed document.)
Q. Blue -- blue granules. Do you -- do you know that the -- do you have an understanding that this TVT mesh is made from a blue pigment?
A. Yes.
Q. And so do you understand that what he's pointing out here are -- are that there are blue pigments that the polypropylene is made from within the cracked layer?
MR. VOUDOURIS: Objection.
A. And, again, he cannot prove there is something overlapping. For instance, you have collagens densely adhesed to these mesh fibers also can show overlapping. Underneath is mesh fiber on H and you -- meanwhile, you

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have dense collagens adhesed to that. Then these collagen also can show linings or cracks, so-called.
Q. (BY MR. THORNBURGH) Okay. So you understand this is a cross-section, right?
A. Yes.
Q. So you're claiming that this -- this outer, cracked layer is collagen, right? Is that what you're claiming?
A. I said could be collagen overlapping in this area.
Q. Okay. But what he's pointing out here is there are blue granules or pigments which the mesh fibers are dyed with, and he observes them within the cracked area.
A. Correct.
MR. VOUDOURIS: Objection; form.
A. That's why I -- I say they could be overlapping. And under microscope, in certain condition, you can still see blue granules. Meanwhile, the -- the collagen covers on the top. You are not able to see.
Q. (BY MR. THORNBURGH) Do you have any evidence of -- of that happening within figure CK8b?
A. It's my understanding; it's not evidence based. It's my -- based on my past experience as a

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pathologist. Because, think it over, the mesh will stay in the human body. It's not going to move around because you have tissue integration. Why tissue integration will hold mesh? Because you have these collagens densely adhesed to the mesh fiber, anchors and fix these mesh fibers.
Q. Go to Page 119 real quick, Exhibit CK8f.
A. Yes.
Q. And do you see that cracked, outer layer identified here in Exhibit CK8f on the outside of the fiber?
MR. VOUDOURIS: Objection; form.
A. Yes, I saw that.
Q. (BY MR. THORNBURGH) Okay. And, again, this is a cross-section of Mrs. Corbet's explant, right?
A. Yeah; he claimed that, yes.
Q. Okay. And again, this is 100X objective, right?
A. Yes.
Q. Have you ever looked at any mesh fibers in this case, Ms. Corbet's case, at 100X objective?
A. No. I -- there is no need to do that.
Q. Okay. And you see again those blue pigments within the cracked layer?
MR. VOUDOURIS: Objection; form.

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A. Meanwhile, it's a purplish.
Q. (BY MR. THORNBURGH) You see those purplish --
A. Right.
Q. -- dots or pigments within the -- or granules within the cracked layer?
A. The purplish is staining, right. And underneath, you may have a few granules. That's a possibility.
Q. Within the cracked layer?
A. Right.
Q. And if there are granules within the cracked layer and Mrs. Corbet's mesh was made out of blue pigments, isn't this some evidence that the cracked layer is actually a polypropylene that was implanted into Mrs. Corbet?
MR. VOUDOURIS: Objection; form, foundation, speculation.
A. You can't confirm that. Okay. Again, just like as I said, there is a possibility you have these overlapping so-called degenerated collagens densely adhesed to the mesh fiber or mesh filament. Then underneath of that, you see blue granule is very common. And plus, collagens, they also can be polarized.
Q. (BY MR. THORNBURGH) So it's very -- so I think what I understood you to say is it's very common

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for you to -- when you look at these explanted meshes on cross-section at a higher magnification to see these blue granules within the layer, the top layer of the mesh --
MR. VOUDOURIS: Objection; form.
Q. (BY MR. THORNBURGH) -- filament?
A. No. It's --
MR. VOUDOURIS: Misstates his testimony.
A. In the 40X or 400 magnification, usually people are not able to see blue granules. And then plus, it's really not necessary to magnify such a high level to visualize what are they because the best way to show is -- if they are truly degraded mesh fibers, then under polarized condition, they will show birefringent property. But many of them, they don't. That's the fact.
Q. (BY MR. THORNBURGH) If you turn the page to 26. Again, this is a lower magnification than Dr. Iakovlev uses, right?
A. This is a 400 probably.
Q. 400X?
A. Yeah. Magnification, I mean.
Q. 400 magnification, which would be 40X, right?
A. 40X is a 400 magnification.
Q. And you write here that "The bark-like

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material does not show the same birefringent properties under the polarized light as the mesh fibers in your image using 40X"?
A. Correct.
Q. Do you know how thick that layer is that you're pointing to?
A. It's several microns, like still similar to maybe 3 to 5 micron, as Dr. Iakovlev mentioned.
Q. And is this something that -- well, strike that.
Did you see this layer in Mrs. -- in all of Ms. Corbet's fibers or just the ones that you used to do polarized light?
MR. VOUDOURIS: Objection; compound.
A. Can you rephrase your question?
Q. (BY MR. THORNBURGH) Yeah. I'm just trying to understand, did you -- when you looked at all of her images --
A. Right.
Q. -- did you try and get close enough to see if there was an outer layer on the outside of the cross-section fiber?
A. Yes. I examined it very carefully.
Q. And were you able to see an outer layer on the mesh fibers at 40X?

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MR. VOUDOURIS: Objection; form.
A. Oh, yeah; it's very clear. And the many so-called bark-like area can be visualized even in the 40X magnification or 100X magnification.
Q. (BY MR. THORNBURGH) Okay. So on -- under section D, your conclusions, you say, "Based on my review of Ms. Corbet's pathology specimens, I conclude the following: No evidence of mesh distortion is identified" [as read]?
A. Correct.
Q. And by "mesh distortion," are you referring to curling or roping?
A. Yeah. Curling, roping, and also including the clinical examination, as stated by Dr. Smith. When she removed the portion of the implants, she did not describe any abnormality there.
Q. And any other basis for that? Just a review of the -- the -- the --
A. And --
Q. -- pathology material?
A. Right. And histologically, all these mesh pictures or figures I have seen, it's very common. Just almost every explanted mesh will show, more or less, similar pictures.
Q. What -- what do you mean by more or less will

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show similar pictures? What do you mean by that?
A. Because mesh, just like Dr. Iakovlev's picture and my picture, you can see lower power they can have this kind of appearance or may have different appearance, right? These -- depending on the -- which plane you cut.
So it does not necessarily -- they are not perfectly round, and then -- then these mesh, they are normal. And then the relationship, like this mesh is round, the other mesh is oval shape. Then they are perpendicular relationship, then it says it's distorted.
Q. Did you see --
A. Nobody can say that.
Q. Did you see in Dr. Iakovlev's report where he discusses where he can see evidence of curling and roping?
A. Yeah. I -- I saw that, but I disagree.
Q. And what -- and what's your basis for disagreeing?
MR. VOUDOURIS: Objection; asked and answered.
A. Can you show exactly which picture that you are referring? Then we will discuss.
Q. (BY MR. THORNBURGH) Yeah. Let me just -- you know the -- the image that you have where you have --

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you identified the possible erosion?
A. Right.
Q. And that was image -- you circled it on --
A. That's on Page 14.
Q. On Page 14?
A. Figure 5.
Q. Page 14, Figure 5 is the slide that you -- microphotograph that you indicated earlier was a probable exposure, right?
A. Correct.
Q. And do you see any evidence that this is laying flat, this -- this mesh that was explanted is laying flat, or does it appear to be curled up here where you see the squamous mucosa?
MR. VOUDOURIS: Objection; form.
A. If you understand the pathology a little better, then you may not ask this question because the specimen process is a random cut, all right?
And also, fresh specimen is different from fixed specimen. Fresh specimen removed by surgeon and have to be placed in the formalin. Then after in the formalin, then tissue being fixed. And by removing the water components, therefore, the specimen shrinks, okay?
So then after specimen shrinks, then these pictures, these mesh can be either way, can be arranged

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very randomly, all right? Even make not only this circle, even can be completely go to this area [indicating].
Q. (BY MR. THORNBURGH) Okay.
A. It does not mean this mesh just distorted.
Q. So let me just make sure I understand your testimony. Do you -- you, I think, are agreeing that the image on Page 14 of your report appears to be distorted, but you cannot say that that was -- happened inside her body rather than something that happened --
A. I --
Q. -- after --
A. -- I did --
MR. VOUDOURIS: Are you done?
MR. THORNBURGH: Yeah.
MR. VOUDOURIS: Objection --
THE WITNESS: Okay.
MR. VOUDOURIS: -- form and misstates his prior testimony.
A. Right. I even didn't say this appeared to curl. That's you -- what you are saying.
Q. (BY MR. THORNBURGH) You said it could have this image and --
A. Right. All these --
Q. -- and you directed --

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A. What I said is all these findings, they are normal finding, okay? Whatever the -- the mesh, they can have a totally different picture, all right? Can have more than 100 kind of different appearance under microscope because the section can be totally different.
Q. Okay. So when I asked you -- when I said distorted or when I was -- strike that.
When I was asking questions about distortion, you said, referring to Exhibit Number 14, that it could appear like this, and you created sort of a roundish -- a round circle as you were demonstrating.
A. Right.
Q. Do you see some evidence of -- of some sort of curling that is happening within this image?
A. We --
MR. VOUDOURIS: Objection.
A. We see all kinds of microscopic representations, including so-called curling. It's not real curling, okay? Because, as I say, tissue, after remove the water, tissue contracts. Then tissue contracts, will change the shape of original mesh in vivo. So it's totally different from in vivo.
Q. (BY MR. THORNBURGH) Okay. So I think you're saying that you can't tell whether or not in Mrs. Corbet's case if there was any evidence of

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distortion because the mesh was explanted and put into formalin; is that right?
MR. VOUDOURIS: Objection; form.
A. That's why I say no -- no histological evidence of distortion.
Q. (BY MR. THORNBURGH) All right. So you're not saying that -- you're not going to opine or offer evidence or suggest that it didn't distort inside her body; you're just stating or offering an opinion that you simply can't make that determination after the mesh has been explanted and put into formalin?
MR. VOUDOURIS: Objection; form, foundation, misstates his testimony.
Go ahead.
A. But based on clinical finding, Dr. Smith did not state any abnormality, for instance, the -- the -- the implanted mesh was displaced or abnormally located, okay? Number one.
Number two, from other publications also -- like ultrasound study also mention based on a several-year follow-up -- I don't remember exactly where it is -- they found that there is no evidence of -- you know, that these implanted mesh will move around or change shape.
Q. (BY MR. THORNBURGH) What study did you

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reference?
A. That's, I think, one of the study that's in the --
Q. Is that the Klinge study?
A. I don't remember which one, but anyway, it's in the thumb drive.
Q. Is that the study? And I'm not -- I don't want to -- I'm just trying to understand what study you're using to base your opinion --
A. It's an ultrasound study to see if mesh actually move -- moved from the year 1 -- or day 1 implantation and then to after 3 years follow-up to see --
Q. That's --
A. -- if they move at all.
Q. That's actually the study where they began to evaluate mesh movement after three months, right?
MR. VOUDOURIS: Objection; form.
A. I think three years, three-year follow-up.
Q. (BY MR. THORNBURGH) So that's your basis for the opinion --
A. It's not the basis. My basis is, first of all, based on my pathological finding, number one. They're very common, all right? Number two is from Dr. Smith's deposition or surgical pathology report --

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or surgical procedure report.
Q. On number 2 you say the -- the second opinion you have is that, "The specimen shows goods tissue integration with mild and focally moderate degree of fibrosis. No evidence of diffuse scar formation or scar bridging is identified" [as read].
And is that the opinion that you have given throughout today?
A. Yes.
Q. "And no evidence of infection present," right?
A. Correct.
Q. You say, "But focal mesh exposure or erosion may be present" [as read].
And that's what you identified?
A. That's what we discussed.
Q. Your next opinion is, "No evidence of nerve entrapment or any abnormal nerve findings in the specimen" [as read]?
A. Correct.
Q. And we discussed that earlier. And the basis for that is your review of these -- is your opinion -- or the basis for that opinion is that finding nerves in -- in or near mesh is a normal finding?
A. Correct.
Q. "The degree of chronic inflammation of foreign

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body giant cells found in the specimen is within normal limits" [as read]?
A. Yes.
Q. And the norm -- you say "normal limits." For what? What is normal limits?
A. Normal limits means almost every explanted mesh should have, more or less, similar degree of inflammation or fibrosis.
Q. So when you --
A. So that means it's -- it's not beyond expectation.
Q. So -- so what -- the way you used the term "normal limits," you're saying that Mrs. Corbet's degree of chronic inflammation of foreign giant cells found in her specimen is consistent with the other specimens that you've explanted or analyzed?
A. Right. Or consistent with similar even nonmesh implants or foreign body. Any foreign body implant to human tissues, they normally -- in normal condition, they should have similar findings.
Q. Okay. So her findings -- the findings that you have analyzing her explant is consistent with the findings that you see in all foreign body explants?
A. Correct.
Q. So normal --

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A. If -- if they are normal.
Q. Normal limits -- when you say "normal limits," you're comparing --
A. That means without infection, all these things. If you -- if the specimen is infected, that's different.
Q. You say here, "No evidence of tissue necrosis," right?
A. Correct.
Q. And -- and then go on to say that "Therefore, there's no cytotoxicity"?
A. Correct.
Q. Okay. And she did have -- as we've already said, you've observed a probable exposure, and clinically, she had an exposure. Are you offering an opinion or stating, representing that when there's cytotoxicity, it does not lead to erosions?
MR. VOUDOURIS: Objection and compound.
A. I said there is no evidence here based on histological findings to suggest any cytotoxicity happened. Because if there is any evidence of cytotoxicity, then we should be able to see cell deaths.
Q. (BY MR. THORNBURGH) So, you know, I've taken the deposition of, you know, internal employees for -- for Ethicon, who've testified that cyto -- that the type

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of symptoms you would expect from cytotoxicity would be an enhanced tissue response or erosion.
MR. VOUDOURIS: Objection.
Q. (BY MR. THORNBURGH) So are -- are you saying that she -- that erosion is not a finding caused by cytotoxicity?
A. There is no relationship for that.
Q. What's the basis for your opinion that Mrs. Corbet's erosion does not suggest or indicate cytotoxicity?
MR. VOUDOURIS: Objection; asked and answered.
A. I have said very clearly here there is no evidence of tissue necrosis or cell deaths in here; therefore, unlikely there is any cytotoxicity there in this -- these tissue from the mesh specimen.
Q. (BY MR. THORNBURGH) You're not a toxicologist, though, right?
A. No.
Q. You're not going to offer opinions as a toxicologist at trial?
A. No.
Q. Have you looked at, in making this opinion about Mrs. Corbet, the internal documents of Ethicon concerning their cytotoxicity results?

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A. No.
Q. Have you read the deposition of Dr. -- Dr. Barbolt concerning cytotoxicity?
A. No.
Q. And so what's the basis -- where do you get the -- this statement or the opinion that if it's cytotoxic, you're going to see necrosis?
A. If it's cytotoxic, that means that these chemicals will kill the cell. That's very simple. And I don't see cell deaths and even tissue necrosis. Therefore, from that point of view, there is no toxic environment there. Is that clear?
Q. Yeah. I'm just trying -- do you have an opinion whether or not cytotoxicity can cause erosion?
MR. VOUDOURIS: Objection; it's beyond the scope.
Q. (BY MR. THORNBURGH) You're not offering that opinion?
A. I'm not going to offer any opinion of that.
Q. Would you defer to people at Ethicon?
A. Or the expert.
Q. And finding there's no histological evidence to support pain or dyspareunia complained of in the patient, right?
A. From -- yes, from histological perspective,

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there is no evidence to support that.
Q. So it's your opinion that the moderate fibrosis that you identified, the focal fibrosis that you identified, is not associated with pain?
MR. VOUDOURIS: Objection; asked and answered.
A. No.
Q. (BY MR. THORNBURGH) Fibrosis doesn't cause pain -- so it's your opinion that the fibrosis that you observed in Ms. Corbet is not causing her pain?
MR. VOUDOURIS: Objection.
A. Correct.
Q. (BY MR. THORNBURGH) And it's not causing her dyspareunia?
A. No direct --
MR. VOUDOURIS: Objection.
A. -- association. I have stated multiple time from a pathology perspective, reading slides can't predict the patient will have pain or not pain, particularly for this case.
Q. (BY MR. THORNBURGH) So the presence -- you're saying, I think, that the presence of an inflammatory response -- strike that.
You cannot offer an opinion to a reasonable degree of medical probability that the

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presence of inflammation is causing her pain?
A. Not only me; majority of the pathologists will have the same conclusion.
Q. And so I think similar to your opinions that you offered regarding the nerves, are you basically -- are you essentially saying that it's impossible to determine that a patient's pain is caused from a pathological finding of inflammation?
MR. VOUDOURIS: Objection.
A. Right. Pain is a clinical symptom and a patient feeling. It's a very complex situation, okay? You understand? So that's --
Q. (BY MR. THORNBURGH) Inflammation -- I'm sorry. I thought you were done.
Inflammation can cause pain, though, right?
MR. VOUDOURIS: Objection.
A. Depending on how much inflammation you have.
Q. (BY MR. THORNBURGH) Do you know -- sorry. Go ahead.
A. For instance, if you have a cut and infected, then lots of inflammation cause erythema, edema, and then you have -- you may have pain. But if you have a mild, chronic inflammation many people have, then we -- particularly, in majority situation, they do not

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feel pain.
MR. VOUDOURIS: Dan, this was --
MR. THORNBURGH: I'm almost done.
MR. VOUDOURIS: I know. This was discussed --
MR. THORNBURGH: The -- well, I'm just --
MR. VOUDOURIS: -- extensively.
MR. THORNBURGH: -- summarizing his opinions.
Q. (BY MR. THORNBURGH) The -- the edema that was -- that Dr. Iakovlev identified is -- it's your opinion that that wasn't edema?
A. Correct.
Q. And if it was edema, if she has edema, is -- is that evidence of pain?
MR. VOUDOURIS: Objection.
Q. (BY MR. THORNBURGH) Can pain cause edema?
MR. VOUDOURIS: Objection.
A. You always use a hypothetical situation. And what I'm -- we are answering is to deal with the realistic things. Whatever we found, then we make statement.
So -- and plus, Dr. Iakovlev only pointed a very focal area with a potential, his interpretation, of edema. And my interpretation is not convinced edema.

Could be loose connective tissue. So therefore, there's no evidence to support patient -- a clinical finding of pain.

Q. (BY MR. THORNBURGH) Does that summarize all of your opinions?

A. Correct.

Q. And finally, I think you testified that you got paid $600 an hour, but does that change for trial? Do you get paid more for trial?

A. No. I think this the same, always the same.

Q. Okay. $600 per hour? Is there a minimum hourly fee per day?

A. For trial, I think I mentioned that the maximum will be either 8 hours or 10 hours, no matter -- I'm not going to include my sleeping hours for -- for the trial.

Q. So -- so you'd get a minimum of $8 per day -- I'm sorry -- a minimum of 8 hours per day at $600 an hour if you appear for trial?

A. Usually that's the case.

Q. Is that in a fee schedule?

A. That's my fee schedule for many years, yes.

MR. THORNBURGH: I think that's it.

THE WITNESS: Okay.

MR. VOUDOURIS: Let's just take a quick

break.

THE VIDEOGRAPHER: We're off record at 5:21 p.m.

(Break taken.)

THE VIDEOGRAPHER: We're back on record at 5:27 p.m.

MR. VOUDOURIS: Dr. Zheng, I have no follow-up questions for you, but the court reporter's going to type this deposition up, and you have the right to read it or waive signature. I suggest you tell her that you'd like to read it, but you have to tell her that.

THE WITNESS: Okay. I have to read it.

THE REPORTER: Okay.

MR. VOUDOURIS: All right.

MR. THORNBURGH: All right.

THE VIDEOGRAPHER: We're off record at 5:28 p.m.

(Proceedings concluded.)

CHANGES AND SIGNATURE

WITNESS NAME: WENXIN ZHENG, M.D. DATE: NOVEMBER 18, 2015

PAGE	LINE	CHANGE	REASON

I, WENXIN ZHENG, M.D., have read the foregoing deposition and hereby affix my signature that same is true and correct, except as noted above.

_____

WENXIN ZHENG, M.D.

THE STATE OF _____)
COUNTY OF _____)

Before me, _____, on this day personally appeared WENXIN ZHENG, M.D., known to me (or proved to me under oath or through _____) (description of identity card or other document)) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that they executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this _____ day of _____, 2015.

_____

NOTARY PUBLIC IN AND FOR
THE STATE OF _____
COMMISSION EXPIRES:

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STATE OF TEXAS)
COUNTY OF DALLAS)

I, LISA C. HUNDT, a Certified Shorthand Reporter in and for the State of Texas, hereby certify that, pursuant to the agreement hereinbefore set forth, there came before me on the 18th day of November, A.D, 2015, at 9:16 a.m., at the office of Thompson & Knight, located at 1722 Routh Street, Suite 1500, in the City of Dallas, State of Texas, the following named person, to-wit: WENXIN ZHENG, M.D., who was by me duly cautioned and sworn to testify to the truth, the whole truth, and nothing but the truth of his knowledge touching and concerning the matters in controversy in this cause; and that he was thereupon carefully examined upon his oath and his examination reduced to writing under my supervision; that the deposition is a true record of the testimony given by the witness, same to be sworn and subscribed by said witness before any Notary Public, pursuant to the agreement of the parties; and that the amount of time used by each party at the deposition is as follows:

Mr. Daniel Thornburgh - 6 hours, 22 minutes,
Mr. Peter Voudouris - 0 hours, 0 minutes,
Mr. Brandon Morris - 0 hours, 0 minutes,
Mr. Andrew Snowden - 0 hours, 0 minutes;

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I further certify that I am neither attorney nor counsel for, nor related to or employed by, any of the parties to the action in which this deposition is taken, and further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto, or financially interested in the action.

I further certify that before the completion of the deposition, ___X___ the Deponent, and/or _____ the Plaintiff/Defendant, ___X___ did _____ did not request to review the transcript.

In witness whereof, I have hereunto set my hand and affixed my seal this 20th day of November, A.D. 2015.

_____
LISA C. HUNDT, CSR, RPR, CLR
Texas CSR No. 6533
Expiration Date: 12/31/16